Medicaid Administrative Match

Local Health Jurisdiction

Training Manual

July 2005

Our Vision: Assure the opportunity for eligible clients to obtain Medicaid Services

Washington State
Department of Social & Health Services

Medical Assistance Administration

A MANUAL FOR MEDICAID ADMINISTRATIVE MATCH IN LOCAL HEALTH JURISDICTIONS

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I. VISION, GOALS AND OBJECTIVES

Vision

- Every eligible individual will have the opportunity to obtain Medicaid services.
- Medicaid services will be accessible and available to those in need.

Goals

- Help more individuals access needed medical services.
- Increase the number of individuals receiving preventive medical services.
- Increase the number of individuals whose medical needs are identified, diagnosed, and treated on a timely basis.
- Improve the coordination, quality, and delivery of Medicaid services to ensure the best use of available financial and provider resources.
- Provide an effective, efficient, compliant and consistent statewide Medicaid Administrative Match (MAM) Program for Local Health Jurisdictions and their contractors.
- Increase the number of medical providers participating in the Medicaid program; improve coordination and support to currently participating providers to ensure their retention in the Medicaid program.

Objectives

- Create a statewide, uniform time survey and claiming methodology for Local Health Jurisdictions to use in managing the AdMatch program that will minimize state and local audit risk.
- Comply with federal and state laws and regulations governing Medicaid administrative match claiming.

II. **PROGRAM OVERVIEW OF THE MEDICAID ADMINISTRATIVE MATCH PROGRAM IN LOCAL HEALTH**

Federal matching funds (also referred to as Federal Financial Participation or FFP) under Medicaid are available for the cost of administrative activities that directly support efforts to identify and enroll potential eligibles into Medicaid, to bring them into services covered by Medicaid, to remove barriers to accessing Medicaid services and to reduce gaps in Medicaid services. To the extent that employees in a Local Health Jurisdiction (LHJ) claiming unit and their contractors perform administrative activities that are in support of the state Medicaid plan, federal reimbursement may be available.

Low-income individuals and families receive Medicaid coverage and services through the State. The pathway to services is provided by the Medical Assistance Administration (MAA), a division of the Department of Social and Health Services (DSHS). The partnership between MAA and the LHJs will ensure that Medicaid-eligible individuals and families will have better access to health care through improved outreach, linkage, interagency coordination, and systems development efforts around Medicaid services.

The Medicaid Administrative Match (MAM) program allows LHJ claiming units and their contractors to earn federal reimbursement for a percentage of specific activities germane to the proper and efficient administration of the state Medicaid Plan. LHJs currently provide the activities reimbursable under the MAM program, at their own expense. Through an Interlocal Agreement, LHJ claiming units can be reimbursed 50% of their allowable costs (and 75% for activities performed by Skilled Professional Medical Personnel working positions that require medical education and training) based on documentation of activities performed.

The Medicaid Administrative Match (MAM) activities, which emphasize outreach to bring eligible clients into Medicaid and linking eligible clients with needed Medicaid services are distinct from services that are provided through Medicaid managed care programs, Medicaid waivers, or Medicaid fee-for-service programs.

The specific Medicaid Administrative Match (MAM) activities that may be billed under a MAC contract with the State of Washington Medical Assistance Administration (MAA) may be found in the Quick Reference section of this web page.

III. MEDICAID ADMINISTRATIVE MATCH: LOCAL HEALTH JURISDICTIONS PROCESS OVERVIEW

STEP 1: Local Health Jurisdiction (LHJ) claiming units that choose to participate in the Medicaid Administrative Match (MAM) program first enter into a contract with the Medical Assistance Administration (MAA). This contract is called an Interlocal Agreement.

STEP 2: The LHJ claiming unit appoints a MAM coordinator. The coordinator attends training sessions on the time survey and activity codes before the LHJ may participate in the program. The coordinator and, as appropriate, a designated fiscal staff person in the LHJ must attend invoice training before the first invoice (the A-19) is submitted. Contractors of LHJ claiming units must be trained by their LHJs prior to participating, and invoices must be submitted through the LHJ claiming unit.

STEP 3: The LHJ claiming unit coordinator determines which staff will participate in the random moment time survey and which staff will use the direct charge method. Staff who qualify as Skilled Professional Medical Personnel are identified and complete necessary forms. Job descriptions are reviewed to ensure SPMP status is required. Duty statements are developed for all job classes participating in the time survey. A training schedule is developed and implemented, so that all participating staff are trained prior to their first time survey, and annually thereafter. Information is provided to implement the random moment time survey; staff doing direct charge are trained on how to report their activities on a daily basis. The coordinator trains staff on how to complete Quality Assurance documentation and reviews this documentation on a regular basis.

STEP 4: The coordinator or other staff, as appropriate, develop a procedure to collect information on the number of clients served by the claiming unit. At a minimum, the information collected will include first and last name, middle initial (if available), date of birth, and gender of all clients served by the claiming unit in the calendar quarter prior to the quarter for which a claim will be submitted. The Medicaid ID number (the PIC) may also be collected. This client data is collected quarterly and sent to WSALPHO to be aggregated and forwarded to MAA in order to determine the quarterly Medicaid Eligibility Rate (MER) for each claiming unit and then to return the eligibility data to the claiming unit.

STEP 5: The quarterly invoice is prepared, with separate A-19 forms submitted for MAM, the DSHS Interpreter Services program, Vaccine Quality Improvement, and Medicaid Outreach and Access for Medicaid Children.

IV. MEDICAID ELIGIBILITY: BASICS

A. Introduction

Medicaid is a national program that is also a set of state-federal partnerships. Established by law in Title XIX of the Social Security Act, Medicaid furnishes medical assistance to specific populations in need. Federal law requires that every state provide certain types of medical coverage to specific populations. In addition, states have the option to cover other populations and services, as long as they meet national standards created by the federal Medicaid program.

Employees or contractors of LHJs participating in the Medicaid Administrative Match program may perform activities that assist individuals to become eligible for the Medicaid program, and help them to access services covered by Medicaid once they are eligible. At the program level, staff may work to identify gaps and barriers in Medicaid-covered services and to engage in planning and program development activities that can overcome these barriers and gaps. Information about the types of Medicaid eligibility available to individuals, and the services each category covers is summarized below, as background to the MAM program.

Within the Medicaid program, the populations groups receiving mandated coverage in accordance with federal law are called the "categorically needy". Individuals receiving medical assistance at state option are known as the "medically needy". In both of these programs, the federal and state governments participate in the cost of the program. The federal share is different for each state, and is indexed annually based on poverty levels and other factors. The federal share of the Medicaid cost of both the categorically and medically needy programs is never less than 50% of the total.

> Categorically Needy (CN) Programs. Individuals eligible for CN programs may also be eligible for cash benefits under the Temporary Assistance for Needy Families program (TANF) or Supplemental Security Income (SSI). The CN program also includes full scope coverage for eligible pregnant women and children.
>
> Medically Needy (MN) Programs. Individuals eligible for MN programs have income and resources above the limits set for the CN program. The MN programs include aged, blind, and disable persons; it also includes pregnant women, children, and refugees with income and/or resources above what is allowed for the CN program. The scope of coverage under the MN program is less that what is offered under the CN program.
>
> Other Federal Medicaid Programs. In addition to the CN and MN programs, there are several other Medicaid programs that have federal funding. The Children's Health Insurance Program (CHIP), Alien Emergency Medical (AEM), the Take

Charge Family Planning Medicaid waiver program, and the Breast and Cervical Cancer Treatment Program are examples of these programs.

State Only Medicaid Programs. The State also supports several medical assistance programs of limited scope for certain classes of individuals. The General Assistance-Unemployable is one such category. The Medical Care Services program is another. As state only programs, there is no federal participation.

B. Eligibility Categories

There are many categories of eligibility for both the CN and MN programs. A description of each of these categories may be found in a document published by the Medical Assistance Administration annually. It is called the Medical Assistance Eligibility Overview and may be downloaded from the MAA website: http://fortress.wa.gov.dshs.maa.

C. Coverage

The covered services chart on the Medical Assistance Administration website lists major services which are available to clients by program: Medicaid CN (Categorically Needy), non-Medicaid MCS (Medical Care Services for GAU and ADATSA), and Medicaid MN (Medically Needy).

D. Medical Assistance Programs

A wide range of medical services is available for low-income individuals and families – including medical assistance programs operated with only state funds. The chart on the following page provides links to descriptions of the major medical assistance programs in Washington State and describes which programs have federal financial participation and which programs do not.

	Full Scope Medicaid	Limited Scope Medicaid	Non-Medicaid
Family Medical	-TANF -Family Medical Program		-State Family Assistance
Woman's Health	-CN Medical Program -Postpartum Extension -Cash Assistance for Pregnant Women	-Family Planning Extension -Non-Citizen Pregnant Women -Breast & Cervical Treatment -Take Charge	
Children's Programs	-CN Medical Program	-Children's Health Insurance Program (CHIP)	
Refugee's & Aliens	-Refugees	-Alien Emergency Medical	
Aged, Blind & Disabled	-SSI/GAX -Healthcare for Workers with Disabilities (HWD)		-General Assistance Unemployable (GAU)
Medically Needy	-Medically Needy		
Basic Health			-Basic Health

D. CUSTOMER TOLL-FREE NUMBERS & USEFUL WEB SITES. Click on this link to find toll free numbers and useful web addresses about the Medicaid program in Washington.

V. THE TIME SURVEY METHODOLOGY

Introduction

While some Local Health Jurisdictions will use continuous time documentation to allocate costs to the Medicaid Administrative Match program, most will use a Random Moment Time Survey (RMTS). Both methods ensure the accuracy and validity of time surveys, a recent concern of the federal Center for Medicare and Medicaid Services (CMS).

The details of both approaches are described below.

The Random Moment Time Survey

1. The RMTS asks the time survey participant to report the activity he/she was performing during the sampled moment using the federally approved activity codes included in the Quick Reference section of this manual. The RMTS is a form of continuous documentation. Samples are drawn for the corresponding quarters in which invoices for Medicaid Administrative Match are submitted. Random moments occur throughout the quarter. The moments are drawn from all the paid workdays in the quarter and all the minutes within these workdays. The random moments can be individualized to the employee's schedule, so they reflect the actual workday hours of all participating staff.

2. The sample is statistically valid. Federal policy has historically set the validity threshold for a random moment time survey at between 2200 and 2400 moments per quarter. While at the statewide level 2400 moments may be statistically valid, each LHJ claiming unit will submit its own invoice, based on its actual expenditures, unique time survey results, and MER.

   The sample size for each claiming unit's RMTS will be determined by the number of participants, up to the statistically valid threshold of 2400 moments per unit. This "tiered" option is well suited to Medicaid administrative claiming in local claiming units, where there is great variation in the number of employees. Staff at DSHS have reviewed the design of the sample and determined that it meets the 95% confidence-level, and complies with applicable federal standards.

3. The following standard will be used to establish the minimum number of moments for each local claiming unit:

   - Local claiming units with 75 or more workers participating in the RMTS will generate a minimum of 2400 valid moments per quarter.

   - Local claiming units with less than 75 workers participating in the RMTS will produce a minimum of 33 valid moments per worker per quarter. Since the sample is drawn randomly, not all workers will receive 33 moments, but the aggregate will be an average of 33 valid moments per worker.

4. Each local claiming unit will also over sample by 10%-20% to cover any invalid time surveys, and to accommodate employee resignations, or interdepartmental transfers that occur during a quarter.

5. The participants in a RMTS will include all staff in Cost Pool #1 and Cost Pool #2 who performs allowable Medicaid administrative activities, as defined by the RMTS Codes 3, 5, 8, 9, 10, 12, 14, 15, 16, 18, 19, 21, 23 and 24. The RMTS will not include individuals who will utilize continuous documentation to support claiming of their time and costs. This is discussed in the following section. Each individual has an equal chance of being sampled during the time survey period. With the use of a tiered approach, each LHJ claiming unit will have its own RMTS, with the statistically significant number of moments needed depending on the number of staff.

6. The RMTS will be managed centrally by the Washington State Association of Local Public Health Officials (WSALPHO). The sample for each participating entity will be drawn at WSALPHO electronically. RMTS forms will be sent or emailed through WSALPHO. RMTS data will be collected and aggregated through WSALPHO as well. Detailed quarterly RMTS reports will be prepared through WSALPHO for each agency. As the emails and response screens are set to the person level, the forms are slightly different for SPMP and non-SPMP staff. No SPMP codes are listed on the non-SPMP forms. The QA notice is included in the RMTS, and the response requires the activity description to be completed.

7. Local claiming units will have the option of using two methods in the RMTS to contact their staff and contractors – direct contact or electronic contact. Prior to the beginning of each quarter, the local claiming unit will send WSALPHO an electronically generated list of their RMTS participants, indicating whether the direct contact or electronic RMTS contact method will be used. Once the list is received, and the data uploaded, the jurisdiction-specific sample will be drawn. The methods are described briefly, as follows:

   <u>The Direct Contact/Observer Method:</u> In the direct contact/observer method, a designated RMTS Coordinator receives a master list of random moments and individual RMTS forms for all staff in his/her program at the beginning of each month of the quarter. When an individual is due to be sampled, the designated coordinator finds the person, asks him/her to complete the form, and collects the signed document. If the worker is not at his/her desk, the coordinator leaves the form for the worker to fill out upon his/her return. In claiming units where staff use pagers or cell phones with a voice mail function and are out of the office at the time of their random moment, the coordinator might contact the worker by leaving a message on the pager or cell phone's voice mail. The coordinator may ask the worker to mark the code that best describes the activity he/she was performing at that moment and leave the form on the worker's desk for signature. The completed forms are sent to WSALPHO for tabulation.

The Electronic Method: In this method, the employee receives an E-mail on the morning of the sample moment. The e-mail will contain the information on the random moment and the list of the time survey codes. The worker records the code that best describes the activity being performed at that moment and either completes the form electronically on a protected web site or prints out the form, completes it and routes it to his/her time survey coordinator. The time survey coordinator will send it on to WSALPHO for data entry and tabulation.

8. As noted earlier, each local claiming unit will create an electronic list of staff to be included in RMTS database each quarter. The database will be updated quarterly to reflect terminations, transfers, schedule changes and new employees. The RMTS will include all staff whose costs will be reported to Cost Pool #1 or #2 on the Automated Detail Invoice. The only exception will be staff that are hired after a quarter begins or who are out on extended leave. New hires will be added at the beginning of each quarter, after they have been trained.

9. Every person in the RMTS has an equal chance of being selected for any given random moment during work hours. The sample selection system considers all participants and all work "moments" for each moment selected.

10. Monitoring will be built into the RMTS process to ensure that staff complete their random moment documentation on a timely basis. Supervisors (or time survey coordinators) will be notified on a weekly basis of the random moments that have been sent to their staff for follow-up on those that have not been completed.

Continuous Time Documentation

Some local claiming units, particularly small ones and some contractors, have systems for continuous, 100% documentation of staff time and are able to direct charge time spent on Medicaid Administrative Match activities. These local claiming units use daily time keeping systems where staff report 100% of their time, by activity code, every day of their work year, either electronically or on paper.

LHJ claiming units doing continuous time reporting over the quarter will report all matchable activity in increments of no less than 15 minutes, which will then be reported as direct charges on the automated invoice. Non-matchable activity will also be reported as a specific program function. In this manner they are able to capture the amount of time and cost allocable to Medicaid administrative match activities.

Local claiming units using this method will incorporate the federally approved MAM activity codes included in the Quick Reference section of this manual into the list of activities employees report on an ongoing basis. All activity is documented in the same manner as the RMTS. SPMP will also note the medical skills/training needed for the activity being performed.

Training requirements are the same as for staff in the RMTS.

VI. COMPREHENSIVE ACTIVITIY CODES

The "Medicaid Match Administrative Claiming Program Activity Codes for Local Health Jurisdictions" contains a set of activity codes that reflect the entire constellation of public health functions, including Medicaid and non-Medicaid activities. Staff will use those codes to document the activity they are performing when they are time surveyed. Matchable activities include codes used by all staff as well as a code used only by Skilled Medical Professionals.

The activity codes work in concert with the other tools described in this manual to accurately identify matchable activities and isolate their costs. As described elsewhere on this webpage, the Automated Detail Invoice identifies all the quarterly expenses of the claiming unit, as well as its funding sources. Consequently, the claiming formula can be completed with a high level of accuracy and precision.

Employees of LHJ claming units often perform both direct services (e.g., medical, vocational or social services) and administrative activities (e.g., outreach or care coordination). The Activity Codes must capture and clearly distinguish direct services from Medicaid administrative activities. Typically, direct services have different funding sources, claiming mechanisms, and documentation requirements related to each program or type of activity, and therefore they should not be claimed as a Medicaid administrative expense. Because the activity codes must represent 100 percent of the time an employee may spend, activity codes are designed to reflect all administrative activities and direct services that may be performed, only some of which are reimbursable under Medicaid.

The activity codes used by LHJ claiming units to document time for the Medicaid Administrative Match claim identify medical and other direct services that are not considered Medicaid related, and ensure that those costs are not included in the claims for Medicaid administrative activities.

The claiming unit must discount all but eight of the Medicaid administrative match activities by the percentage of Medicaid eligibles served. Matchable activities that need to be provided by Skilled Professional Medical Personnel (SPMP) are matched at 75% while all others are matched at 50%. Outreach to bring eligibles into Medicaid is matched at 50%, with a100% Medicaid Eligibility Rate, as are outreach and linkage activities around oral health for children who are Medicaid beneficiaries. In addition, some activities, where the purpose and cost is clearly identifiable as 100% related to Medicaid administrative activities, may be direct-charged, without being discounted by the Medicaid eligibility rate

A summary grid of the Comprehensive Activity Codes may be found in the Quick Reference Section.

VII. SKILLED PROFESSIONAL MEDICAL PERSONNEL

Introduction:

Local Health Jurisdictions may employ staff who meet the federal qualifications to be designated as Skilled Professional Medical Personnel (SPMP). With such designation, the LHJ claiming unit has the potential to be reimbursed at the enhanced rate of 75% FFP for the cost of time reported to the activities codes subsumed under Code 9: SPMP Medical Care Coordination. Documenting that SPMP meet all the federal requirements that are a condition of enhanced reimbursement is critical. The federal laws and regulations that govern SPMP status are described below, as well as the requirements for qualifying as an SPMP.

Statutory Basis for SPMP

- Section 1903(a)(2) of the Social Security Act provides for increased FFP for medical staff, as follows:

  > "…an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel of the State agency or any other public agency…"

- The intent of section 1903(a) (2) is to encourage States to employ medical staff with professional medical expertise to develop and administer Medicaid programs that are "medically sound as well as administratively efficient."

- "Professional medical knowledge" is necessary to shape the medical aspects of the program. Skilled professional Medicaid personnel are distinguished from skilled professional medical personnel.

Regulatory Basis for SPMP

Final revised SPMP regulations were issued on Nov. 12, 1985, superseding any previous regulations and policy guidelines by the Health Care Financing Administration (now CMS) or its predecessor agency. 42 *Code of Federal Regulations (CFR)* 432.2 defines directly supporting staff, skilled professional medical personnel and staff of other public agencies. Section 432.45 specifies that the enhanced FFP is not available for state personnel who conduct survey activities and certify facilities for Medicaid participation.

Section 432.50, in part, specifies that 75% FFP is available for staffing and training costs of SPMP and directly supporting staff of the Medicaid agency of other public agencies and that the allocation of their costs must be based on either the actual percentages of time spent carrying out duties in the specified areas or another methodology approved by HCFA.

Section 432.50(d) (1) (i-v) delineates other limitations on FFP, including a definition of professional education and training. And lastly, 42 *CFR* 433.15 states that 75% FFP is available for compensation and training of SPMP and staff directly supporting them if all criteria in 432.50 (c) and (d) are met. (Please refer to the Appendix for the text of these regulations.)

Criteria for Determining SPMP

There are seven specific criteria that must be satisfied. They are:

(1) The expenditures that qualify for enhanced FFP are salary or other compensation, fringe benefits, travel, per diem and training of SPMP and their directly supporting staff when they are performing activities that are directly related to the administration of the Medicaid program. Operating expenses (e.g., rent and supplies) and indirect costs charged directly or allocated to these personnel qualify for 50% FFP.

(2) SPMP have professional education and training in the field of medical care or appropriate medical practice. This is defined as completion of a two-year or longer program leading to an academic degree or certificate in a medically related profession, demonstrated by possession of a medical license, certificate or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization.

The medical license or certificate must document the minimal two-year professional education and training requirement. In other words, an individual with a certificate or license (such as a licensed practical nurse) does not automatically qualify as an SPMP if s/he has not completed the requisite two-year degree program in the field of medical care.

There is a recent financial review guide issued by CMS mentions using the "American Universities and Colleges" reference guide, compiled by the American Council on Education, to check on degree fields considered medical in nature (those listed under "Health Professions") and whether a college or university is certified by a professional medical organization.

Several Departmental Appeals Board decisions have discussed SPMP status by professional degree and license as part of their rulings in a particular case. These discussions are summarized below:

Psychology. The Review Guide notes that the Departmental Appeals Board (DAB), in Decision No. 1033, determined that a Ph.D. in psychology together with a State license to practice as a psychologist meets the educational requirement for SPMP status.

Medical Social Work. According to the Review Guide, the issuance of DAB decisions on medical social work prompted the federal agency to "rethink policy regarding professional education requirements." The threshold for social workers to qualify as SPMP is "'…if their education (including training received as part of academic work) specifically included the health care and/or medical applications of the social work field.' Work experience or on-the-job training could not be substituted for meeting the educational requirements."

State agencies must show that social workers' education and training in social work specifically includes health care and/or medical applications. The Review Guide notes that States should use graduate level concentrations, or specializations or tracks, as defined by various MSW programs, to identify those social workers that would be eligible for the enhanced rate.

CMS also recommends that States demonstrate an "education equivalency" for every social worker being claimed as SPMP where the schools they attended do not offer medical or health concentrations, or where they are offered but the social worker did not compete one.

CMS laid out guidelines for its auditors to use when reviewing MSWs being claimed as SPMP. State agencies must show that each social worker has an MSW degree, and as part of the course work for the master's degree, a specialization (track or concentration) in clinical practice, health care practice, other medical application, or its equivalent.

The CMS Financial Review Guide specifies the equivalency standards, as follows:

a) Completion of a graduate degree at a school that offered health care or medical specializations but the social worker formally concentrated in another area. The social worker would qualify if he/she completed as many health courses as would be required for a concentration in health care.

b) If the applicable graduate program offers concentrations, but none distinctly in health care or medical applications, the transcript must show at least as many credits received in health care as would be required for any of the concentrations offered. For example, if a minimum of four courses is required for any concentration, the transcript must show completion of at least four courses in health or medical applications.

c) If the applicable MSW program did not offer concentrations at all, the transcript must show more credits received in health care or medical applications than in any other specialized area of study.

No amount of on-the-job experience in a Medicaid agency or any other job or employment situation can be substituted for professional education and training."

In these earlier DAB decisions, it was clear that states needed to distinguish between medical social workers and individuals with an MSW degree without a medical or health focus. The DAB, in its findings, considered the education/training of individual social workers. It stressed that having medical coursework or courses with medical application of social work, including field work in a health or medical setting, was the standard, and that on-the-job training or work experience did not apply. The DAB, however, refrained from establishing the actual courses or numbers of courses that qualified, but rather considered these on an individual basis.

A later DAB decision in West Virginia (Decision No.1434) in 1993 mentioned the CMS standard of a medical or health care concentration. However, it did not specifically apply this standard when reviewing individual social workers in this appeal; the DAB again looked at courses and field placements with medical/health care content.

The Review Guide's use of the medical or health care concentration as the criterion, or alternative "education equivalency" requirements, narrows the definition of SPMP status for social workers.

The "concentration" and "equivalent education" standards were applied in a 2004 Office of the Inspector General (OIG) audit of SPMP payments received by the West Virginia Bureau for Medical Services. The OIG recommended a refund of claims for social workers that did not have a master's degree in social work nor had a master's degree but the State did not have documentation that the graduate course work included the required specialization [in clinical practice, health care practice, other medical application, or its equivalent].

(3) SPMP must be in positions that have duties and responsibilities that require those professional medical knowledge and skills. The function performed by the SPMP must require that level of medical expertise to be performed effectively. The primary evidence of this would be position descriptions, job announcements or job classifications.

The Review Guide states that the reviewer may also want to establish whether the position is listed in a handbook or dictionary of occupational titles as an appropriate medical classification (such as the Occupational Outlook Handbook, Bureau of Labor Statistics, U. S. Department of Labor or the Standard Occupational or the "standard Occupational Classification Manual," National Technical Information Service, U. S. Department of Commerce).

Examples of functions that would meet the "functional" criteria include, but are not limited to, the following:

- Acting as a liaison on the medical aspects of the program with providers of services and other agencies that provide medical care.
- Furnishing expert medical opinions for the adjudication of administrative appeals.
- Reviewing complex physician billings.
- Providing technical assistance and drug abuse screening on pharmacy billings.
- Participating in medical review or independent professional review team activities.
- Assessing the necessity for and adequacy of medical care and services provided, as in utilization review.
- Assessing, through case management activities, the necessity for and adequacy of medical care and services required by individual recipients. (Excluded is case management provided under an approved HCBS waiver.)

The Review Guide also listed functions that do not require professional medical expertise and therefore do not qualify for 75% FFP. CMS notes in the Guide that this list is not all-inclusive.

- Accounting and auditing
- Budgeting
- Program management for categories of services not requiring medical expertise: emergency transportation, non-emergency transportation, and home and community-based waiver services.
- Program analysis where the emphasis is cost or utilization of services in lieu of the medical aspects of the program.

- Cost reimbursement including all analytical work, related to the program cost of covered services, cost report settlement, and establishment of rates.
- Program integrity including any investigation and follow-up activities not directly involving the determination of the medical necessity of specific services.
- Third party liability activities/overpayment collection activities.
- Administrative practices and procedures including the development of State plans, administrative rates, cost allocation and provider agreements.
- EPSDT, including all outreach activities such as notifying clients of required screens from a periodicity schedule, scheduling appointments, informing clients and arranging transportation.
- Eligibility determination
- Legal services including administrative appeals.
- Contract management.

FFP would be available at 50% for an otherwise qualified SPMP performing a function which is unrelated to the specialized field of medical care and requires no skilled medical training. Time spent by a qualified SPMP on supervisory related administrative functions such as personnel, staff meetings, counseling, etc., would be allowable at 50% FFP. When a team performs an SPMP function (e.g., medical review team), each individual team member must qualify as an SPMP to claim his/her time at the enhanced rate.

(4) A state-documented employer-employee relationship must exist between the Medicaid agency (or any other public agency) and the SPMP and directly supporting staff. .

The federal interpretation here is that the personnel are under the State's merit personnel system in all aspects as documented by the State's personnel and payroll system and records. For the most part, 75% FFP is not allowed for contractors with private organizations or independent contractors. In situations where the Medicaid agency (or any other public agency) contracts directly for personal services as a common method of securing services of an SPMP, it must demonstrate that a documented employer-employee relationship exists directly between them and the Medicaid agency (or any other public agency). The Review Guide tells its reviewers to examine the substantive relationship between the parties on a case-by-case basis. The standard laid out in the Guide follows:

> "Generally, if the substantive relationship specified in the contract indicates that the Medicaid agency or any other public agency has control over when, where, and how the contractor works, we would allow this level of control to indicate that a documented employer-employee relationship exists, even though that person may not be under the State's merit personnel system as documented in the personnel and payroll record systems of the State."

It does not include employees of a State's fiscal agent or other contractor, who may contract with or employ SPMPs directly. These contracts would be reimbursed at only 50% FFP.

(5) Directly supporting staff are secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that are directly necessary for the completion of the professional medical responsibilities and functions of the skilled professional medical staff. The skilled professional medical staff must directly supervise the supporting staff and the performance of the supporting staff's work.

The Review Guide notes that "support staff" is defined in the congressional reports as "clerical staff," who are interpreted to be those mentioned in the previous paragraph. The Guide notes that other sub professional staff, such as administrative and management assistants, statistical or accounting clerks, office managers, technicians, cannot be claimed at the enhanced rate, if they provide support to SPMPs.

There must be documentation or other evidence that the "direct support" (defined as clerical services, such as typing, filing, copying, preparing correspondence, preparing records and other general office work) is directly related and necessary to the completion of the professional medical functions of the SPMP. The SPMP must be immediately responsible for the work performed by the clerical staff and must directly supervise (immediate first-level supervision) the supporting staff and the performance of that staff's work. The best evidence of this, according to the Review Guide, would be that the SPMP is responsible for the supporting staff's performance appraisal.

Enhanced (75%) FFP is allowed only for that portion of the clerical time related to the performance of the SPMP's skilled medical functions.

(6) The rate of 75% FFP is available for SPMP and directly supporting staff of other public agencies if all of the applicable criteria in items 1-5 are met and the public agency has a written agreement with the Medicaid agency to verify that those requirements are met.

Where SPMP and directly supporting staff employed by pubic agencies other than the Medicaid agency assist in the administration of the Medicaid program, they may claim 75% FFP for the costs of salary or other compensation, benefits, travel, per diem and training as long as there is a written interagency agreement specifying that the staff and their functions meet the applicable criteria.

The agreement should also spell out the "directly related" duties that the other public agency will perform—those necessary to the operation of the Medicaid program. An entity is considered public if it is part of State and local government and subject to supervision and control of a governmental unit; the receipt of Federal funding in itself does not bestow public status to a private agency.

(7) FFP must be prorated for split functions for SPMP and directly supporting staff.

Only the portion of an individual's working time that is spent in performing SPMP duties can be reimbursed at 75% FFP. Where the SPMP and directly supporting staff spend less than 100% of their time in SPMP functions, their costs must be allocated among all functions, based on actual time spent in each function or another approved methodology. According to the Review Guide, CMS accepts current timesheets kept by the SPMP personnel or some form of sampling methodology. Proration is needed when an SPMP is also a supervisor performing general administrative functions that must be claimed at 50% FFP.

VIII. THE MEDICAID ELIGIBILITY RATE (MER)

Overview

The Washington State Association of Local Public Health Officers (WSALPHO) sponsored the development of a Medicaid Administrative Match Steering Committee composed of representatives of a cross section of Local Health Jurisdictions to address issues related to the implementation of the new Administrative Match contract. The Steering Committee created a methodology for calculating the Medicaid Eligibility Rate (MER), which has received federal approval.

The MER methodology recognizes differences in size and organization of the 35 different Local Health Jurisdictions (LHJs) in Washington State. Some jurisdictions are as small as Wahkiakum County, which has a population of 3,900, one clinic and four public health staff. The largest is Seattle King County Public Health Department, with nearly two million county residents, eleven large public health clinics and a staff of over 2,000. The disparities in county and LHJ size are a variable that has been taken into account by the design of the Washington State Medicaid Eligibility Rate (MER) methodology for local health jurisdictions.

Calculating the MER

Validation by MAA

At the close of every quarter, each LHJ claiming unit will submit files in a common format to WSALPHO where they will be merged into one file. The files will consist of an unduplicated case count of all clients seen during the previous quarter by LHJ claiming units that perform Medicaid Administrative Claiming activities. Each LHJ claiming unit will keep supporting documentation in its audit files explaining how its file was created.

The file layout will include the Personal Identification Code (PIC) code, when available, for each client served, as well as other identifying information. At a minimum, core data fields will include full first name, middle initial or middle name, full last name, and birth date. This data will be compiled and submitted to the Department of Social and Health Services (DSHS) in a format recommended by them.

WSALPHO will act in the same capacity as OSPI does on behalf of local school districts. Like OSPI, WSALPHO will be the central point for gathering the local data and will be responsible for ensuring an unduplicated client count and ensuring proper layout of data for the file. After receiving the file, MAA will verify the data against their eligibility information for same time period. MAA will generate a report for WSALPHO that identifies clients who were enrolled in Medicaid programs during the quarter. Prior to the actual enrollment verification, representatives from WSALPHO and MAA will meet to develop the criteria for achieving the verification and methodologies to address discrepancies.

The MER will include all Medicaid programs where there is federal participation.

Once WSALPHO receives the verification data from MAA, WSALPHO will disaggregate the file in order to establish a unique MER for each LHJ claiming unit. To calculate the MER percentage for each claiming unit, the number of positive matches with the eligibility file will constitute the numerator and the total unduplicated number of clients served by the LHJ claiming unit for the previous quarter and reported in the MER file will constitute the denominator.

The MER is linked to the administrative unit called a "claiming unit", whose staff participates in the RMTS, and whose expenses and revenues and unique approved indirect rate will be reported on the invoice. This unit is clearly defined in a table of organization, and serves and collects data on a distinct group of clients. The close link of the MER to the administrative unit that serves the clients in the MER strengthens the consistency and inter-relatedness of the data supporting the MAM invoice.

Quarterly Calculation of the MER

The MER will be calculated quarterly, and LHJ claiming units will all apply the prior quarter's eligibility data to the current quarter claim. This will ensure that there is adequate time for both the LHJs and DSHS/MAA to collect data and aggregate the eligibility verification data, and to provide the respective claiming units with their specific data once the verification is complete. For example, the claim for the April-June quarter of 2005 will use MER data from the January-March 2005 quarter. The July-September quarter claim will use data from the April-June quarter, and so on. All LHJ claiming units will use the prior quarter MER as the basis for the current quarter claim to ensure consistency and uniformity across the state.

XI. QUALITY ASSURANCE

The documentation requirements needed as part of a quality assurance (QA) process are built into both time documentation systems - the RMTS and the continuous documentation method. All random moments will be documented for quality assurance. The worker will be instructed to write down what he or she did as well as the code used, to ensure that the activity is consistent with the coding. The QA data will be collected at the same time the random moment is reported and aggregated through WSALPHO. The results are sent back to the local claiming unit biweekly to help identify issues to address in training.

To meet the CMS request for continuous documentation of Skilled Professional Medical Professional (SPMP) activity, SPMP staff will be instructed that each time they report an SPMP activity in the RMTS, they will document that activity. They will note the activity performed, and the medical/clinical/nursing skills that were used to perform the SPMP activity. SPMPs using continuous documentation will also describe the medical/clinical/nursing skills used for any SPMP activity that is reported, along with the activity code.

Examples from actual Quality Assurance documentation may be found in the Quick Reference section of this manual.

X. Other Documentation

Program Duty Statements

For each LHJ claiming unit participating in the Medicaid Administrative Match program, Program Duty Statements will be developed. The duty statements must describe the purpose, duties, responsibilities, functions and activities of the claiming unit. The job classifications of employees whose costs will be claimed on the Automated Detail Invoice and the A-19 must be listed in the Program Duty Statement.

Position Duty Statements

In addition, Position Duty Statements will be developed for each job class participating in the RMTS or continuous documentation. The Position Duty Statements must describe the MAM-related duties and functions.

Draft Program and Position Duty Statement formats and examples of completed Program and Position Duty Statements may be found in the Quick Reference Guide.

Medicaid Resources

Local Health Jurisdictions will also develop and maintain a resource file of Medicaid services that may be accessed by their client/patient population. This file will be available to all employees participating in the time survey, and whose costs are included in the invoice. One element of this resource file will provide information on providers that accept Medicaid clients.

XI. INTERPRETER SERVICES

Introduction

Interpreter services provided under the terms of an agreement with DSHS-MAA for the Interpreter Services Program will be documented and invoiced using the revised methodology for Medicaid administrative claiming described in this Manual. The automated invoice will calculate the amount of reimbursement that will be claimed for the Interpreter Services Program, and transfer this amount to a separate A-19 for Interpreter Services. The Interpreter Services A-19 will be submitted to the Interpreter Services Program at MAA, along with a copy of the automated invoice.

Interpreter services provided by an LHJ claiming unit or its contractor as part of an agreement with the Interpreter Services Program must be furnished by an interpreter who has been certified by the State or qualified by the LHJ to perform these services. Interpreters will report their matchable time to one of three activity codes included in the time survey. They are:

Code 14: Interpretation for Medicaid-Covered Medical Services
Code 15: Interpretation for Medicaid Related Outreach Activities
Code 16: Interpretation for Medicaid Related Linkage Activities

Documentation and Reimbursement Requirements

A. Interpretation for Medicaid-Covered Medical Services

1. Reimbursement will only be provided for interpretation provided on behalf of Medicaid beneficiaries who receiving Medicaid billable services.

2. Expenditure detail related to this activity will be reported on the automated invoice for Medicaid Administrative Match (MAM) prepared quarterly by a Local Health Jurisdiction Claiming Unit and summarized on an A-19 for Interpreter Services. The invoice permits allowable expenditures to be reimbursed via one of two methods: allocation based on the results of the Random Moment Time Survey RMTS) or direct charge.

3. If costs for this activity are based on the RMTS, all moments reported to Code 14 on the survey (Interpretation for Medicaid-Covered Medical Services) will be documented with a brief description of the activity and the MAID (Medicaid ID) of the client for whom the services were provided.

   The automated invoice will identify the total costs associated with this activity, and transfer them to the A-19 for Interpreter Services. A 100%

Medicaid Eligibility Rate will apply, as all individuals benefiting from this activity will be Medicaid beneficiaries.

4. If the direct charge method is used, the interpreter will report the amount of time spent on Code 14 throughout the quarter. The MAID of each person receiving interpreter services will be included in the report. At the end of the quarter, the actual cost of the interpreter's service will be reported on the direct charge worksheet of the automated invoice, and then summarized on the A-19 for Interpreter Services.

   The actual cost of the interpreter includes salary, fringe benefits, actual operating or other costs, and a proportionate share of agency administrative costs that are not otherwise included in a state or federally approved indirect rate. Supporting documentation must be prepared to show how administrative costs were developed and maintained in the agency's MAM audit file.

   If an agency has a state or federally approved indirect rate, it may also be applied to these costs. A 100% Medicaid Eligibility Rate will apply here as well, as all individuals benefiting from this activity will be Medicaid beneficiaries.

B. Interpretation for Medicaid Related Outreach Services

1. Reimbursement will only be provided for interpretation related to campaigns, programs or ongoing activities targeted to 1) bringing potential eligibles into the Medicaid system for the purpose of determining eligibility or 2) bringing Medicaid eligible individuals into specific Medicaid services.

2. Expenditure detail related to this activity will be reported on the automated invoice and summarized on an A-19 for Interpreter Services. The invoice permits allowable expenditures to be reimbursed via one of two methods: allocation based on the results of the RMTS or direct charge.

3. If costs for this activity are based on the random moment time survey, all moments reported to Code 15 on the survey (Interpretation for Medicaid-Related Outreach Services) will be documented with a brief description of the activity.

   The automated invoice will identify the total costs associated with this activity, and transfer them to the A-19 for Interpreter Services. A 100% Medicaid Eligibility Rate will apply, as permitted by the federal Center for Medicare and Medicaid Services.

4. If the direct charge method is used, the interpreter will report the amount of time spent on Code 15 throughout the quarter, along with a brief

description of the activity performed. At the end of the quarter, the actual cost of the interpreter's service will be reported on the direct charge worksheet of the automated invoice, and then summarized on the A-19 for Interpreter Services.

The actual cost of the interpreter includes salary, fringe benefits, actual operating or other costs, and a proportionate share of agency administrative costs that are not otherwise included in a state or federally approved indirect rate. Supporting documentation must be prepared to show how administrative costs were developed and maintained in the agency's MAM audit file.

If an agency has a state or federally approved indirect rate, it may also be applied to these costs. A 100% Medicaid Eligibility Rate will apply here as well, as permitted by the federal Center for Medicare and Medicaid Services.

C. Interpretation for Medicaid Related Linkage Services

1. Reimbursement will only be provided for interpretation that assists individuals to access Medicaid-covered services.

2. Expenditure detail related to this activity will be reported on the automated invoice for Medicaid Administrative Match (MAM) prepared quarterly by a Local Health Jurisdiction Claiming Unit and summarized on an A-19 for Interpreter Services. The invoice permits allowable expenditures to be reimbursed via one of two methods: allocation based on the results of the RMTS or direct charge.

3. If costs for this activity are based on the random moment time survey, all moments reported to Code 16 on the survey (Interpretation for Medicaid-Related Linkage Services) will be documented with a brief description of the activity.

   The automated invoice will identify the total costs associated with this activity, and transfer them to the A-19 for Interpreter Services. The discounted Medicaid Eligibility Rate (MER) will apply, to recognize that some the interpreter services may be provided to individuals whose Medicaid status is not known, but who need assistance in accessing medical services. The MER is the same MER that LHJ claiming units will apply to other matchable Medicaid administrative activities, and which is reported on the Automated Detail Invoice, and calculated quarterly according to guidelines established in the LHJ Manual for Medicaid Administrative Match.

4. If the direct charge method is used, the interpreter will report the amount of time spent on Code 16 throughout the quarter, along with a brief description of the activity performed. At the end of the quarter, the actual cost of the interpreter's service will be reported on the direct charge worksheet of the automated invoice, and then summarized on the A-19 for Interpreter Services.

   The actual cost of the interpreter includes salary, fringe benefits, actual operating or other costs, and a proportionate share of agency administrative costs that are not otherwise included in a state or federally approved indirect rate. Supporting documentation must be prepared to show how administrative costs were developed and maintained in the agency's MAM audit file.

   If an agency has a state or federally approved indirect rate, it may also be applied to these costs. As described in Item #3 above, the discounted MER will be applied.

XII. OUTREACH AND ACCESS TO ORAL HEALTH CARE FOR MEDICAID CHILDREN

Introduction

Time and costs associated with the performance of activities related to outreach and access to oral health care for Medicaid children aged 0-18, as reported to Code 10, may be included on the automated invoice. The automated invoice will calculate the amount of reimbursement that will be claimed for these activities, and transfer this amount to a separate A-19 for Outreach and Access to Oral Health Care for Medicaid Children. This A-19 will be submitted to the program manager at MAA responsible for these activities, along with a copy of the invoice.

Activity Description:

Code 10: Outreach and Access to Oral Health Care for Medicaid Children
MER: 100%

Use when recruiting providers to accept Medicaid children into dental care and performing outreach to link Medicaid children 0 - 18 years into timely oral health care.

Examples of activities reported under this code include:

- Outreach targeting dental and medical providers, community agencies, media and potential clients.
- Referring Medicaid enrolled children aged 0-5 to the ABCD dental program.
- Referring Medicaid enrolled children aged 0-18 to oral health care.
- Development and maintenance of an information clearinghouse & referral/resource information on the availability of dental care for Medicaid children, including the ABCD program.
- Client orientation sessions within the community to reduce barriers and improve client behavior and program participation.
- Assessment of client and provider satisfaction.

XIII. VACCINE QUALITY IMPROVEMENT SERVICES

Introduction

Time and costs associated with the performance of vaccine quality improvement services as reported to Code 18 and Code 9F may be included on the automated invoice. The automated invoice will calculate the amount of reimbursement that will be claimed for these activities, and transfer this amount to a separate A-19 for Vaccine Quality Improvement Services. This A-19 will be submitted to the program manager at MAA responsible for these activities, along with a copy of the invoice.

Allowable Activities:

Code 18: Vaccine Quality Improvement/Child Profile

All staff may use this code.

Use when performing activities that do not require skilled professional medical education or training to administer or support the vaccine quality improvement program. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities. Administering immunizations/vaccines and other direct medical care should be reported to Code 1: Direct Patient Care.

Examples include:

- Data entry related to Child Profile, the State immunization registry. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.
- Routine administrative functions related to ordering and distributing vaccines – filling and tracking orders, distributing vaccines, developing provider agreements, coordinating and performing monthly count of available vaccines, assisting providers to complete the monthly count, and preparing monthly vaccine reports.
- Routine administrative functions related to storing vaccines – tracking vaccine inventory by vaccine type, dose, and manufacturer lot number, package and handling of vaccine.
- Overseeing the contracts and accounting of doses of federally and state-supplied vaccine.
- Conducting routine quality assurance activities such as monitoring of refrigeration temperature logs.

Code 9F: SPMP Vaccine Quality Improvement

Only staff who are Skilled Professional Medical Personnel (SPMP) may use this code when their skilled professional medical education and training are required to perform the activity.

Includes *SPMP Vaccine Quality Improvement* activities performed by Skilled Professional Medical Personnel that oversee and coordinate the medical aspects of vaccine programs in local health jurisdictions.

Examples include:

- Developing and monitoring of clinical protocols for storage and handling of vaccine to ensure their quality.
- Clinical monitoring of the handling and distribution of vaccines. Includes site reviews to ensure the medical quality of vaccine administration and of the medical protocols used in vaccine programs.
- Providing and exchanging medical information to or with medical providers to ensure the overall quality of vaccine programs – appropriate uses and dosages, adverse effects, interpretation of medical guidelines, epidemiology, standards of care, and other clinical concerns.
- Recommendations to medical providers to maintain quality vaccine programs, such as handling vaccine storage and administration incidents, such as whether to continue use of vaccine not properly refrigerated and whether to recommend revaccination.
- Administering immunizations/vaccines and other direct medical care should be reported to Code 1: Direct Patient Care.

XIV. THE AUTOMATED DETAIL INVOICE

Overview

A. Contract Changes

In recent years, the federal government has made revisions to they way State Medicaid programs implement Medicaid administrative claiming programs. A higher level of standardization is being required, including the following:

- Consistent methods to document time spent on Medicaid administrative activities;
- Some level of documentation of activities claimed as Medicaid administrative costs;
- Common methodology to determine the Medicaid Eligibility Rate; and
- Higher standards of documentation, including duty statements describing the Medicaid administrative activities performed by staff participating in a time survey.

To bring more standardization to the actual claim for Medicaid administrative activities, the State Medicaid Match Task Force, composed of LHJ representatives under the auspices of the Washington State Association of Local Public Health Officers, (WSALPHO) has modified an automated invoice that has been successfully implemented in local health departments in California to use as the supporting documentation for the A-19.

B. Overview of the Invoice

The objective of this section of the Manual is to explain the automated invoice, how it works and how to fill it out. The invoice documents:

- ALL expenses incurred by the claiming unit during the quarter being billed;
- ALL funding sources supporting the claiming unit; including funding that can be used as local match and funding that cannot be used for that purpose;
- ALL time spent on MAM activities during the quarter being billed; and
- The percentage of all clients served by the claiming unit that are enrolled in federal Medicaid programs.

With this data, the invoice automatically incorporates the data in the Funding/Revenue and Direct Charge Worksheets into the invoice and computes the amount of federal reimbursement.

C. Before Entering the Data

Before entering data into the invoice it is recommended that the following tasks be completed. This will expedite the completion of the invoice, and a better understanding of its structure.

1. *Expenditures:*

   - Identify all staff with expenditures in the claiming unit for the quarter being claimed. Their personnel and benefit costs will be assigned to one of six Cost Pool(s), as discussed in **Section IID – Constructing Cost Pools below**.

   - Identify other expenditures that can be assigned to specific employees (mileage, cell phone, etc.). The expenditures can be assigned to the same cost pool as the employee. If these other costs cannot be assigned to an employee, report them as "other costs" in Cost Pool 6. Make sure these costs are not in the agency's approved indirect or overhead rate.

   - With the assistance of an organization table, review the expenditures included in the agency's indirect cost plan or federally negotiated indirect rate (FNIR) to assure there is no duplication between costs assigned to the indirect rate and expenditures that will be included on the invoice under salaries, benefits, or other costs. Overhead costs related to the claiming unit that is **not included** in the FNIR or overhead rate may be placed in Cost Pool #6.

2. *Funding:*

   - Determine whether any of the cost related to Medicaid administrative activities is supported by a federal grant or its required match. If necessary, recognize that these funds are already being used to support the cost of MAM by "offsetting" them on the Funding Worksheet. This will ensure that no duplicate claims are made to the federal government for MAM activities that are already supported with federal funds.

   - Classify fund sources by type, e.g., insurance, Medicare, etc.

   - Determine the purpose of the funding (e.g., direct patient care, counseling, outreach) in order to allocate the funding to the appropriate cost pool.

*NOTE: While costs are assigned to a cost pool based on the workers assigned to that pool, assigning funding is determined by its **purpose**, not necessarily the associated workers. Because funding is normally for a service or product, it is often not identified with a worker or groups of workers in the same way that salaries and benefits are identified. The rationale for assigning a funding source to a specific cost pool should be documented and retained as part of the audit file.*

II. Reporting Expenditures on the Invoice Worksheet

A. Getting Started

The various worksheets that comprise the invoice have been written in Excel. Before using the invoice file/disk for the first time, it is recommended that a back-up copy of the file/disk be made.

The automated invoice and its supporting worksheets allow the preparer to enter expenditures, funding sources, activity percentages, discount percentages and heading information only once. The data entered on the supporting worksheets will automatically carry forward to other sheets. The lines and columns where data can be entered are marked with the word "**Enter**"; these cells are not shaded. All other sections of the invoice are automatically calculated and are shaded. FORMULAS and FORMATS MUST NOT BE ALTERED in any way, as this will distort the calculations, including the amount of federal financial participation (FFP). Cells containing formulas will be locked to reduce the risk of error in completing the invoice.

To start, make sure you have made a back-up copy of the invoice in case any of the formulas are accidentally typed over or deleted. Data to be input is obtained from internal sources, such as accounting system reports, spreadsheets, journals, payroll records etc. Only those data elements (cells) that appropriately reflect expenditures and funding sources applicable to the claiming unit and the quarter being claimed should be included. Once all the items are entered, the spreadsheet will calculate the amount of Federal Financial Participation (FFP) in the claim.

All data entered on the claim must have documented evidence linking it to the specified cost pool or funding source designation and must be maintained in the audit file. For example, salaries and benefits assigned to SPMP and reported in Cost Pool 1 should be evidenced by payroll documentation to show the expenditure of such salaries and benefits on individuals who qualify as SPMP.

A check-off list of materials that should be retained in an audit file (per your contract and the record retention requirements) is in the Quick Reference section of this manual.

B. How to Enter Percentages

Cells that require a percentage to be entered have already been formatted to display as a percent. When entering percentage data in these cells, use the decimal form. For example:

35%	should be keyed as	".35"
5 %	should be keyed as	".05"
100%	should be keyed as	"1"

C. Rounding

All numbers should be rounded to two (2) decimal places. If the third decimal place is a "5" or higher, round up. Otherwise, round down. For example:

35.674%	should be entered as	"35.67"
12.075%	should be entered as	"12.08"
49.463%	should be entered as	"49.46"

D. Constructing Cost Pools

For each quarter claimed, **all** costs and funding sources for the claiming unit must be assigned to one of the cost/funding source pools (CP) or be direct-charged. The Local Health Jurisdiction has the option of including all costs/funding sources for a program or to include only those costs/funding sources for the claiming unit that performs matchable activities and will be reimbursed through the claiming process. The second option is only permissible if the costs are in a separate budget unit and can be separately identified.

1. Cost Pool 1 – Skilled Professional Medical Personnel (SPMP)

Staff whose costs should be included in Cost Pool 1 are:

- Staff who have been designated as Skilled Professional Medical Personnel (SPMP) and have participated in the time survey or have been doing continuous documentation.
- Clerical staff who only work for, are supervised by, and provide "direct clerical support" to the SPMP in Cost Pool 1, who did not time survey, and who are not a part of the indirect rate. (The table of organization must show that the clerical staff work exclusively for SPMPs in Cost Pool #1.
- Supervisors who only supervise the SPMP in Cost Pool 1, who did not time survey, and who are not part of the indirect rate.
- Supervisors of clerical staff who work for and provide "direct clerical support" only to the SPMPs in Cost Pool 1.
- Personal service contractors who participated in the time survey or are paid on a vendor basis, who have been designated as SPMP, and for whom an employer/employee relationship with the agency can be demonstrated. If paid on a vendor basis, appropriate documentation must support the cost of matchable activities performed.

Note: If the clerical staff or supervisors split their time between cost pools and do not themselves participate in the time survey, and have costs that are not in the indirect rate, their expenses will be reported to Cost Pool #6 in order to be allocated between other cost pools, in proportion to their expense.

2. Cost Pool 2 – Non-SPMP

Staff whose costs should be included in Cost Pool 2 are the following:

- All other staff who participated in the time study.
- Clerical staff who work for the staff in Cost Pool 2 who are not part of the indirect rate.
- Supervisors of the staff in Cost Pool 2 who did not themselves time survey and are not part of an indirect rate.

- Supervisors of clerical staff who support only the employees in Cost Pool 2, did not time survey, and are not part of the indirect rate.
- Personal services contractors who have not been designated as SPMP and/or for whom an employer/employee relationship cannot be demonstrated. If paid on a vendor basis, appropriate documentation must support the cost of matchable activities performed by the personal services contractor.

3. Cost Pool 3a – Non-claimable

This cost pool includes expenses associated with staff in the claiming unit who did not participate in the time survey, are not administrative or support staff, and are NOT included in any of the other cost pools or on the Direct Charges Worksheet. This typically includes staff who provide fee for service direct patient care including treatment, counseling, clinical services, lab services, or other non-claimable activities of the claiming unit.

Cost Pool #3a also includes expenditures that have no relationship to Medicaid administrative activities – medical supplies and equipment, educational materials, malpractice insurance, etc.

4. Cost Pool 3b- Non-claimable balance from Direct Charges Worksheet
(FORMULAS ONLY - DO NOT ENTER DATA)

This cost pool represents the difference between total costs reported in the Direct Charges Worksheet and the direct charges that are claimable. **Data is not directly entered into this cost pool.** These costs will be identified on the Direct Charges Worksheet, and automatically transferred to the invoice worksheet. The cells for this cost pool contain formulas and should not be altered. The costs in Cost Pool 3b are subsequently transferred to Cost Pool 3a, Line L, on the first page of the Detail Invoice.

5. Cost Pool 4 – Direct Charges Enhanced
(FORMULAS ONLY – DO NOT ENTER DATA)

Cost Pool #4 represents expenditures reported on the Direct Charges Worksheet that are reimbursed at the enhanced rate of 75% FFP. **Costs are not directly entered into this cost pool**. These costs will be automatically transferred from the Direct Charges Worksheet to Cost Pool #4. The cells for this cost pool contain formulas and should not be altered.

6. Cost Pool 5 – Direct Charges Non-Enhanced
(FORMULAS ONLY – DO NOT ENTER DATA)

This cost pool represents expenditures from the Direct Charges Worksheet that are reimbursed at the non-enhanced rate of 50% FFP. **Costs are not directly entered into this cost pool.** These costs will automatically be

transferred from the Direct Charges Worksheet to Cost Pool #5. The cells for this cost pool contain formulas and should not be altered.

7. Cost Pool 6 – Allocated Cost and Revenue

Expenditures reported to this cost pool include general or administrative staff in the claiming unit who:

- Did not time-survey **AND**
- Whose costs are **not included** in any department/program (internal) or in the countywide (external) **indirect rate** – **AND**
- Whose costs are not direct charged – **AND**
- Who, by the nature of their work, provide administrative, supervisory or clerical support to staff in other cost pools.

The staff may include management, secretarial, fiscal, supervisory, and clerical staff not included in the other cost pools. Their cost will be automatically allocated to the other cost pools based in proportion to their personnel costs.

E. Entering Data on the Invoice

The Federal Government requires that actual expenditures for the quarter being claimed be reported. The disposition of federal funds may not be reported on the basis of estimates. Therefore, costs must be claimed when they have been actually incurred, not estimated. Line A: Enter the **salary** costs of the staff assigned to CP1, CP2, CP3a, and CP6.

Line B: Enter the **benefit** costs of the staff assigned to CP1, CP2, CP3a, and CP6.

Note: Benefits should be determined by the standard conventions of the accounting system. Exact amounts should be used if they are available. However, if these costs are normally computed as a percentage of salaries, use this method to determine benefit costs.

Line D: Enter the cost of **personal services contractors** in CP1, CP2, and CP3a.

Line H: Enter the **other costs** directly attributable to CP1, CP2, and CP3a if they can be properly identified. Otherwise, enter the "**other costs**" on line H of CP6 for allocation to the other cost pools. Generally, the "other costs" include the normal day-to-day and monthly operating costs necessary to run the claiming unit.

1. The Indirect Rate

Internal indirect costs typically include the costs of a department's administrative and office staff, as well as staff from legal, fiscal accounting, personnel, etc. External indirect costs typically include the costs of central control agencies, such as the County Executive, Human Resources, Prosecuting Attorney, etc. Combined together they are known as the Federally Negotiated Indirect Rate (FNIR) or overhead rate.

Indirect costs claiming principles for federally subsidized agencies are promulgated under the federal Office of Budget and Management (OMB) Circular A-87; therefore, indirect costs may be referenced as "A-87."

External indirect cost rate plans (ICRPs), usually prepared through the county/city Auditor-Controller's Office, must be submitted to and approved by the State Controller's Office. Internal ICRPs must be prepared and on file with the LHJ for each claiming unit. Both these plans must be prepared in accordance with the provisions of OMB Circular A-87 to withstand an audit. **Under no circumstances should the costs of staff included in either the indirect cost rates or Direct Charges Worksheet also be included as a specific cost in any of the cost pools. This would be double claiming.**

The indirect rate is entered on the Other Information Worksheet as a percentage. A claiming unit may have a federally or a state approved indirect rate, and should indicate the one being used on the appropriate line. A claiming unit's approved indirect rate may apply to personnel costs or to all costs. There is a line on the Other Information Worksheet to indicate whether the indirect rate applies to personnel or to all costs.

Once the indirect rate is entered on the Other Information Worksheet, indirect costs are automatically calculated and reported on Lines HA or HB of the invoice.

2. Other Costs

Attachment 3 identifies costs that may be included in "Other Costs."

If they are not otherwise included in the indirect rate, costs that may be included as allowable other costs include:

Office supplies
Printing and duplication costs
Personnel and payroll services costs
Office furniture
Computers and software
Purchased clerical support
Utility costs
Vehicle rental/amortization and fuel
Facility security services
Agency publication and advertising costs
Professional association affiliation dues
Legal representation for the agency
Data processing costs
Office maintenance costs
Repair and maintenance of office equipment
Property and liability insurance (excluding malpractice insurance)

Building/space costs (with capitalization limits)
Indirect costs when determined to be in accordance with OMB Circular A-87

III. Entering the Medicaid Eligibility Rate (the MER)

The MER to be used for the claiming unit for the quarter being claimed is entered on the Other Information Sheet at Line G13. Once entered here, the invoice populates pertinent cells with the MER. The exception is the "Other Costs" section of the Direct Charges Worksheet, where the MER applicable to the specific charge is entered.

The MER is applied to Medicaid allowable activities. Some activities use a 100% MER; others must be discounted by the percentage of clients in the claiming unit who are on Medicaid. The MER is based on the percentage of clients served by a claiming unit who are on Medicaid, and is created for each quarterly claim using data from the prior quarter. See Section VIII of this manual for additional information.

Activity codes that use a 100%, non-discounted MER are identified on lines AA, AC, AH, AL, AM, AU and AV of the invoice, and listed below. A percentage of 100 percent has been put into the spreadsheet for these activities and **must not be altered**.

- Medicaid Outreach (AA)
- Facilitating Medicaid Eligibility (AC)
- Outreach for Oral Health for Medicaid Children (AH)
- Arranging Transportation for Medicaid Services (AJ)
- Interpretation for Direct Medical Services for Medicaid Clients (AL)
- Interpretation for Medicaid Outreach (AM)
- Medicaid Claims Coordination/Claims Administration (AU)
- MAM Implementation Training (AV)

IV. Entering Time Survey Activity Percentages

Lines AA-AZ: Enter Random Moment Time Study percentages for Cost Pool #1 and Cost Pool #2. The percentages for claiming units using the Random Moment Time Surveys may be found in the quarterly report of time survey results that is sent to each LHJ coordinator by the WSALPHO contractor. The results for SPMP should be entered in Cost Pool #1. Non-SPMP results are entered in Cost Pool #2.

Claiming units that use continuous documentation should aggregate all time reported by staff whose costs will be included in the invoice by activity code, and determine the total percentage of time spent on each, for both SPMPs and non-SPMPs. Working papers that support this calculation should be maintained in the audit file.

The total time reported to the activity codes for each cost pool must equal 100 percent. Remember to enter the percentages in decimal form.

V. The Funding Worksheet

A. Overview

The Funding Worksheet identifies **ALL** funding sources supporting expenditures reported on the invoice. Funding sources reported on the Worksheet should equal or exceed the costs reported on the invoice. Only funding that supports expenditures included in the claim will be reported on the Funding Worksheet.

To offset funds means to subtract funds received for a specific purpose from the expenses associated with that purpose.

Some funds may need to be offset on the Funding Worksheet to determine the net cost that will be matched by the Federal Government. Funding should be offset to the applicable cost pool based on its purpose.

The purpose of offsetting funding against cost is to arrive at the net cost in which the Federal Government is willing to share. In determining when to report funding, each claiming unit should consult its annual budget.

Funding should generally be recorded against the corresponding cost of the period. If it is anticipated that funds will be received at one time for the entire year, it is reasonable to divide these funds to report a portion of them on each quarterly claim. If the entire annual revenue is reported in one quarter, it may more than offset that quarter's cost, resulting in the need to refund money to the Federal Government because costs were overstated in other quarters within a given fiscal year.

Unanticipated revenue for the current fiscal year, or for a prior fiscal year not previously offset, should be offset in the current fiscal year as explained above. Should the aforementioned revenue be received in the last quarter of the current fiscal year, it must be reported in that quarter.

The purpose of the Revenue Sources/Funding Worksheet is to list **ALL** funding sources of the claiming unit. To arrive at the net cost that will be the basis for federal reimbursement, it is necessary to offset all non-claimable funding sources. This ensures that the amount of the claim is adjusted downward by the amount of federal funds (including match) being used to support matchable activities.

B. Offset Funds

The following are funds that must be offset; (i.e. subtracted from applicable costs before the net reimbursable cost is determined, and the amount of Federal Financial Participation (FFP) is established.

1. All Federal grant or contract funds, along with maintenance of effort and other state/local matching funds that are required by the federal grant/contract must be

offset against the applicable Cost Pool. (If the grant pays for direct patient care, then it would be assigned to CP#3 as a non-claimable expense. If the federal grant specifically pays for activities that can be claimed under Medicaid administration, then this revenue must be assigned to the employee's Cost Pool and offset from the claim.

EXAMPLE:

- *A federal grant pays for a program that provides outreach to improve access to and use of prenatal care services for homeless women.*
- *The grant covers a nurse, limited operating costs, and a modest indirect rate.*
- *Total funding (for the nurse) is $45,000.*
- *The time survey results show that the nurse spent 40% of her time on Medicaid administrative activities, and 60% of her time on non-allowable activities.*
- *40% of his/her cost (or $18,000) of the grant would be offset to Cost Pool #1, on the row called "Federal Grants", and $27,000 offset to Cost Pool #3.*

2. All state general funds previously matched to the Federal government for other grants or contracts.

3. State and local general funds as well as private funds <u>specifically</u> earmarked for the delivery of non-matchable activities (direct patient care, public education, etc.).

4. Insurance or fees collected from non-governmental sources for the delivery of direct client services must be offset if the related expenses are included in the invoice.

If revenue does not fall into one of these categories, it may be used as "match" for Medicaid Administrative Match (MAM) claiming, and not offset. Non-offset revenue is reported in the column identified as "Not Offset Funds" of the Funding Worksheet, on the row that is appropriate to its source. Again, this is revenue available as "match" to the invoice and would normally be revenue like state or county general funds that have not otherwise been matched to another federal grant or contract, or allocated for another purpose other than MAM activities.

C. <u>Reporting Funding Sources</u>

All the funding supporting the claiming unit should be reported in one of the seven sections of the Funding Worksheet. Each section is for a different type of revenue, as follows:

- Medicaid fees and the applicable match
- Federal grants/contracts and applicable match
- State general funds
- County general funds
- Insurance
- Fees
- Other Funding

If extra lines are required for a particular section, they should be inserted just above the "Total" line. The formulas will not be affected by the additional line(s) if so inserted. Adding lines to the Funding Worksheet may cause the worksheet to print out on multiple pages. All pages must be submitted with the invoice.

List the name of the funding source in the first column, along with the appropriate reference to the general ledger account. Do not use abbreviations.

Use the "Purpose" column to identify the purpose of each funding source. This should be brief, but descriptive enough that the reviewer can determine if the funding has been assigned to the proper cost pool.

D. Assigning Funding Sources to Cost Pools on the Funding Worksheet

Before entering any data on the Funding Worksheet, please follow these steps:

- Classify funding sources by type, i.e., insurance, Medicare, etc.
- Determine the purpose of the funding, i.e. direct patient care, counseling, outreach, etc.
- Assign the funding source to the appropriate cost pool.

The "Not Offset Funds" column is for identifying those funding sources that do not need to be offset against costs. As stated above, this would include county general funds, and all other general purpose funding sources that may be used to support the performance of Medicaid administrative activities. The total amount of "Non-Offset" funds should be equal to or greater than the total cost of MAM-related activities for which federal reimbursement will be earned. If the amount of "Non-Offset" funds is less than these costs, then it can be assumed that federal, non-matchable funds are being used to pay for the cost of matchable activities, and they will need to be offset. This will result in a net reduction to the amount being claimed.

The remaining columns on the Funding Worksheet are for assigning funding sources that must be offset to the appropriate cost pool. Each section has columns identifying the cost pools that may be offset. "XXX's" have been inserted where it is **not** appropriate to assign funding sources.

In this part of the invoice, remember that cost pools are associated with the purpose of a funding source, not its expenditures.

- Funding sources that are NOT associated with any particular activity or NOT identified to a specific cost pool, but should be offset against the claiming unit because of their purpose, should be assigned to Cost Pool #6. This allocates the funds to be offset to the other cost pools based on total costs.

- Funding requiring offset, which is received for activities that are being direct charged, must be assigned to Cost Pool #3, Cost Pool #4 and/or Cost Pool #5 in accordance with the applicable percentage of cost allocated to non-claimable, enhanced, and non-enhanced activities.

- Funding supporting non-claimable, non-administrative activities (billable services and direct patient care as well as operating expense that has no link to Medicaid administrative activities - medical supplies, malpractice insurance, etc.) should be assigned to Cost Pool #3.

Only funding sources for MAM where costs are in Cost Pool 1 or Cost Pool 2 should be assigned to Cost Pool 1 or Cost Pool 2 on the Funding Worksheet. Funding sources for non-claimable activities should be assigned to Cost Pool 3.

> *For example, a Public Health Nurse who performs both matchable and non-matchable activities participates in the time survey. All expenditures directly related to this nurse will be assigned to Cost Pool 1. Funding received for payment of direct health care should be assigned to Cost Pool 3. Funding for any other non-matchable activity should be also assigned to Cost Pool 3.* ***ONLY funding received for matchable activities of this nurse should be assigned to Cost Pool 1.***

Once all the funding sources have been assigned, the Funding Worksheet will automatically add the columns and transfer them to the Invoice Worksheet . The Funding Worksheet contains a certification statement and must be signed and submitted with the completed invoice.

VI. The Direct Charges Worksheet

Allowable costs for time and resources related to the MAM Program are determined through either a time survey or are separately identified and direct-charged. The purpose of the Direct Charges Worksheet is to capture costs determined through methodologies other than the random moment time survey or continuous documentation of all activity.

Costs to be direct-charged must be tracked on an ongoing basis throughout the fiscal year. These costs are separately itemized on the Direct Charges Worksheet and included in the audit file maintained by the LHJ.

A. Categories of Direct Charges

There are six categories of costs that may be direct charged:

1. MAM Coordination and Claims Administration.
2. Other matchable activities.
3. MAM contracts with “specific” matchable activities in their contracts.
4. Other costs that can be easily identified as specifically pertaining to the performance of matchable activities.
5. Contracted Interpreter Services Program costs.

1. MAM Coordination and Claims Administration

Direct charging is permitted for the costs of staff performing MAM Coordination and Claims Administration at the LHJ level or MAM Claims Administration at the claiming unit level. These activities are not reduced by the Medicaid Eligibility Ratio. Each staff performing the activity must be separately listed with the corresponding percentage of time identified. By signing the Direct Charges Worksheet, the preparer certifies the percentage of time associated with MAM Coordination and Claims Administration. A separate certificate statement is not required.

Direct charging is also permitted for the "Other Costs" of staff performing MAM Coordination and Claims Administration. For example, other costs that may be direct charged include printing costs, directly related travel, or equipment used exclusively for the execution of the MAM Program.

2. Other Matchable Activities

Direct charging may also be used to report costs for staff that perform one matchable activity only. This activity may be performed 100% of the time, or may be episodic in nature. In either case, the individual will need to document the time spent on this activity, and include QA documentation for all activity. Costs reported on the Direct Charges Worksheet should be backed up with a description of the methodology used to calculate the allowable costs.

The allocable share of salaries and benefits may be claimed for staff performing a single matchable activity. In addition, directly related operating costs may be included, as well as a fair share of the approved indirect rate, and any other allocable agency overhead costs.

3. MAM Contractors

If a claiming unit enters into a subcontract for the performance of Medicaid administrative activities, the costs may either be direct charged or reported on a separate invoice. Costs may be direct charged when the scope of the contract includes the specific Medicaid administrative activities that will be performed, the staff who will be performing the activity, the amount for each unit of Medicaid administrative activity performed, and pertinent deliverables.

4. Other Costs

Non-personnel costs associated with the performance of MAM activities may also be direct charged. The activity associated with these costs must be identified. Additionally, it must be determined whether the cost must be reduced/factored by the Medicaid Eligibility Ratio. The discount factors for non-personnel costs may be different from the staff performing MAM activities.

5. Interpreter Program Costs

The Direct Charge Worksheet may be used for claiming expenses associated with the DSHS Interpreter Services Program, when the LHJ has an agreement with DSHS for this program, and has certified or qualified interpreters performing the activities. Claiming unit staff who are performing interpreter services under such an agreement may be direct charged, if interpreting is all they do.

The costs of contracts for interpreter services may also be direct charged. Interpreter services must be documented per the terms of the DSHS agreement, and the actual time spent on the three allowable interpreter activities must be kept on an ongoing basis.

Interpreter services are separated out of the FFP claim on the Invoice Worksheet so that they may be reported to a separate A-19. Once the claiming entity reports actual interpreter time and/or expense, the invoice automatically calculates the amount of FFP.

C. Organization of the Direct Charges Worksheet

The Direct Charges Worksheet is divided into a grid. Enhanced and non-enhanced costs are reported in two parallel columns (Section 1 is for enhanced costs, Section 2 for non-enhanced. The grid also contains three horizontal sections. The first is for agency costs where the 100% MER will be applied, the second for agency costs where a discounted MER is used. The third section is used to report costs that would fall into Category 3,4, or 5 of the direct charges listed above – contract costs, other (non-personnel related) costs of the agency, and contracts for the DSHS Interpreter Services Program.

Separate columns have been set up for reporting salaries, benefits, travel/training, personal services contracts, and other costs related to each of the direct charged activities. The MER does not need to be entered in Part 1 or Part 2. The 100% MER remains constant in Part 1. The claiming unit's discounted MER is entered in Part 2 from data entered in the Other Information Worksheet.

Supporting documentation for each of the expenditures reported on the Direct Charge Worksheet is to be maintained in the claiming unit's audit file. This includes descriptions of any methodologies used to allocate or assign costs that will be direct charged.

When determining which costs are to be direct charged, remember that those costs cannot appear anywhere else in the invoice because this would result in duplicate claiming.
Costs are entered in unshaded cells only.

VII. The A-19

The automated invoice contains the information needed to populate the MAA form that summarizes the claim for federal reimbursement – the A19. The invoice populates the data needed for the A-19 automatically.

Separate worksheets in the invoice have been created for the A-19 forms that will be used for the MAM claim, the DSHS Interpreter Services claim, the Vaccine Quality Improvement claim, and the Outreach and Access for Oral Health for Medicaid Children claim. Each of these A-19 forms will be submitted to the designated program manager in MAA. A signed copy of the invoice, along with the funding, the direct charge, and the other information worksheets should be submitted with each A-19 form.

MEDICAID ADMINISTRATIVE CLAIMING PROGRAM
STATE OF WASHINGTON – LOCAL HEALTH JURISDICTIONS
QUESTIONNAIRE FOR SKILLED PROFESSIONAL MEDICAL PERSONNEL
FOR USE BY PHYSICIANS, NURSES AND OTHER MEDICAL FIELDS

Name _____ Job Title _____

Agency _____ Program _____

County _____ Claiming Unit _____

The following information will be used to document the status of employees as Skilled Professional Medical Personnel (SPMP) under the Medicaid Administrative Claiming program. Please respond to all of the questions. Thank you.

1. **Are you a physician licensed to practice medicine in the State of Washington?**
___ YES ___ NO

If YES, please provide your license number _____ and valid dates_____, sign this form and turn it in to your supervisor.

If you answered NO to Question 1, please proceed to Question 2.

2. **Have you completed an educational program in a medical field at a college or university certified by a professional medical organization? (Examples of medical fields are nursing, dietetics, audiology, and dental hygiene.) ___YES ___NO**

If you answered NO, you do not need to fill out the remainder of this questionnaire. Please go the last page, sign this form and turn it in to your supervisor.

If YES, did your educational program last at least two years? ___Yes ___ No

If YES, please list the highest academic degree you received in a medical field, the subject in which it was received, and the name of the college/university where it was received, and then proceed to Question 3.

Academic Degree _____

Field/Subject Area _____

College or University _____

If you answered NO, you do not need to fill out the remainder of this questionnaire. Please go the last page, sign this form and turn it in to your supervisor.

.

3. **Did your educational program lead to licensure by a National or State medical licensure organization?** (An example is a State license as a registered nurse.) **___YES ___NO**

If YES, please provide license type, number, valid dates, and licensing organization. Then sign this form and turn it in to your supervisor.

License Type _____ License Number _____

Valid Dates _____

Licensing Organization _____

If you answered NO to this question, please proceed to Question 4.

4. **Did your educational program lead to certification or registration by a medical or health-related National certifying organization (such as the American Speech and Hearing Association), or State of Washington certifying organization? ___YES ___NO**

If YES, please provide certification/registration type and number, valid dates, and the name of the certifying organization. Then please sign this form and turn it in.

Certificate/Registration Type _____

Certificate/Registration Number _____ Valid Dates _____

Certifying/Registry Organization_____

_____ _____

Employee Signature Date

MEDICAID ADMINISTRATIVE CLAIMING PROGRAM
STATE OF WASHINGTON - LOCAL HEALTH JURISDICTIONS
QUESTIONNAIRE FOR SKILLED PROFESSIONAL MEDICAL PERSONNEL
FOR USE BY SOCIAL WORKERS AND OTHER ALLIED HEALTH PROFESSIONALS

Name _____ Job Title _____

Agency _____ Program _____

County _____ Claiming Unit _____

The following information will be used to document the professional education and training in the field of medical care or appropriate medical practice, a requirement for Skilled Professional Medical Personnel (SPMP) under the Medicaid Administrative Claiming program. This form should be completed by employees with a background in social work, psychology, counseling and other allied health professionals (such as MPHs). Please respond to all of the questions. Thank you.

1. *THIS QUESTION IS TO BE COMPLETED BY SOCIAL WORKERS ONLY*

(a.) Have you completed a master's degree in social work from an accredited two-year graduate program? ___ YES ___ NO

If YES, please answer items (b-e) below. If NO, please stop, sign the form and turn it in to your supervisor.

(b.) Please list the academic degree and the name of the college/university where it was received.

Academic Degree _____

College or University _____

(c.) As part of your MSW degree program, did you complete a concentration, specialization or track, in clinical practice, health care practice, or other medical application?
__ YES ___ NO Other concentration? ___ YES ___ NO

Please list the concentration, specialization or track. _____

(d.) If you did not complete a concentration in clinical or health care practice or other medical application, did you take any courses that had medical or health-related focus (for example, about health, mental health, substance abuse or medical social work)? (NOTE: This does <u>not</u> include continuing education courses or credits.) ___YES ___NO

If YES, please list these courses (including credit hours) below. If more space is needed, please use the back of this form.

Course Name	Credit Hours
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

If you answered NO to Item 1(d) above, please stop, sign this form and turn it in to your supervisor.

(e.) Did part of your two-year or longer MSW program involve medical or health-related training, including field work or internships (for example, in the area of health, mental health or substance abuse)? (Note: This refers to a practicum or field placement linked to your MSW program, and does <u>not</u> include work experience or on-the-job training. It may **include a medical or clinical field experience in a non-medical setting, such as a school or prison.) ___ YES ___ NO**

If YES, please describe each applicable fieldwork or internship (including credit hours), note the setting in which it occurred and your responsibilities or experiences.

Type of Fieldwork/Internship_____ Credit Hours_____

Setting (Agency) _____

Responsibilities/Experiences_____
_____
_____

Type of Fieldwork/Internship_____ Credit Hours_____

Setting (Agency) _____

Responsibilities/Experiences_____
_____
_____

Please proceed to Question 3.

2. *THIS QUESTION IS TO BE COMPLETED BY ALL OTHER ALLIED HEALTH PROFESSIONALS (EXCEPT MSWs)*

(a.) Have you completed an accredited professional educational program in a health or health-related field at a college or university that lasted at least two years? (Examples are clinical psychology, marriage and family therapy, or masters of public health.) ___ YES ___ NO

If YES, please list the highest academic degree you received in a health or health-related field, the subject in which it was received, and the name of the college/university where it was received.

Academic Degree _____ Field/Subject Area _____

College or University _____

If you answered NO to this question, please stop, sign this form and turn it in to your supervisor. Otherwise, please proceed to item (b.)

(b.) As a part of your two-year or longer educational program, did you take any courses that had a medical or health-related focus (for example, about health, mental health, or substance abuse? (NOTE: This does <u>not</u> include continuing education courses or credits.) ___YES

___**NO**

If YES, please list these courses (including credit hours) below. If more space is needed, please use the back of this form.

Course Name Credit Hours

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

(c.) Did part of your two-year or longer educational program involve medical or health-related training, including field work or internships (for example, in the area of health, mental health or substance abuse)? (Note: This refers to a practicum or field placement linked to an educational program, and does not include work experience or on-the-job training. It may include a medical or clinical field experience in a non-medical setting, such as a school or prison.) ___ **YES** ___ **NO**

If YES, please describe each applicable fieldwork or internship (including credit hours), note the setting in which it occurred and your responsibilities or experiences.

Type of Fieldwork/Internship_____ Credit Hours_____

Setting (Agency) _____

Responsibilities/Experiences_____
_____
_____
_____

Type of Fieldwork/Internship_____ Credit Hours_____

Setting (Agency) _____

Responsibilities/Experiences_____
_____
_____
_____

Please proceed to Question 3.

3. **Did your educational program lead to licensure by a National or State medical licensure organization? (An example is State licensure as a psychologist or clinical social worker.)** ___**YES** ___**NO**

If YES, please provide license type, number, valid dates, and licensure organization, then sign this form and turn it in to your supervisor.

License Type _____ License Number _____

Valid Dates _____

Licensure Organization _____

If you answered NO to Item 3 above, please proceed to Question 4.

4. Did your educational program lead to certification or registration by a medical or health-related National or State certifying organization? ___YES ___NO

If YES, please provide certification/registration type and number, valid dates, and the name of the certifying organization.

Certificate/Registration Type _____

Certificate/Registration Number _____ Valid Dates _____

Certifying/Registry Organization_____

Please sign this form and turn it in to your supervisor.

_____ _____
Employee Signature Date

REMINDERS FOR SKILLED PROFESSIONAL MEDICAL PERSONNEL

- You may use the codes reserved for Skilled Professional Medical Personnel (SPMP) if you meet the following qualifications:

  A. You are in a position that requires skilled medical professional education and training, based on your job description.

  B. You have completed program of two years or longer leading to an academic degree or licensure or certification in a medically related field (M.D., P.A., R.N., LVN with a two-year program, master's level social worker) or a degree in a medical field from an accredited university or college program.

  C. You work for a public agency.

- Code 4: SPMP Outreach to Medically-at-Risk Individuals and the SPMP Medicaid Care Coordination activities included in Codes 9A – 9I are enhanced codes reserved by use by SPMP. These SPMP codes should be used only when you are using your professional medical knowledge and skills to perform the activity. In other words, does the activity routinely require a specific level of medical expertise and training to perform? If it does not, then the non-SPMP version of the activity code should be used.

- The use of SPMP codes has recently come under more scrutiny by the federal government in some settings. Therefore, it is important to distinguish between activities (or the portion of an activity) that require medical expertise and training and those that do not.

- *A rule of thumb*: Use the SPMP code when, in your professional judgment, you used your medical knowledge and skill to perform the activity. If the same activity could be performed for the same purpose or with the same result by staff without your same medical knowledge and skill, then do not use the SPMP code.

- The following examples may provide further guidance in using the SPMP codes.

  - *SPMP Skilled Professional Medical Consultation and Assistance:* A registered nurse consults with a group of child care providers about caring for children with seizure disorders and the appropriate responses to medical emergencies they may experience.

  - *Non-SPMP Referral, Linkage, Coordination & Monitoring of Medical Services:* A registered nurse assists a parent to schedule an appointment for her child with a pediatric neurologist.

  - *SPMP Interagency Coordination of Medicaid Services:* A licensed audiologist attends an interagency task force meeting to work on developing new clinical protocols for infant hearing screens and follow-up at local hospitals.

  - *Non-SPMP Community Resource Development, Systems Planning and Interagency Coordination of Medicaid Services:* A licensed audiologist attends a monthly meeting of an Aging Services task force; data on the elderly' s access to speech, language and hearing aid services is reviewed.

  - *SPMP Outreach to Medically-at-Risk Individuals:* A licensed clinical social worker uses her clinical assessment skills to identify at-risk teen mothers who might benefit from behavioral health services covered by Medicaid.

  - *Non-SPMP Medicaid Outreach:* A nutritionist provides information to a single mother on the availability of Early Periodic Screening, Diagnosis and Treatment (EPSDT) services for her children, and how to enroll in Medicaid.

Skilled Professional Medical Personnel

Introduction:

Local Health Jurisdictions may employee staff who meet the federal qualifications to be designated as Skilled Professional Medical Personnel (SPMP). With such designation, the LHJ claiming unit has the potential to be reimbursed at the enhanced rate of 75% FFP for the cost of time reported to the activities codes subsumed under Code 9:SPMP Medical Care Coordination. Documenting that SPMP meet all the federal requirements that are a condition of enhanced reimbursement is critical. The federal laws and regulations that govern SPMP status are described below, as well as the requirements for qualifying as an SPMP.

Statutory Basis for SPMP

- Section 1903(a)(2) of the Social Security Act provides for increased FFP for medical staff, as follows:

  > "…an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel of the State agency or any other public agency…"

- The intent of section 1903(a) (2) is to encourage States to employ medical staff with professional medical expertise to develop and administer Medicaid programs that are "medically sound as well as administratively efficient."

- "Professional medical knowledge" is necessary to shape the medical aspects of the program. Skilled professional Medicaid personnel are distinguished from skilled professional medical personnel.

Regulatory Basis for SPMP

Final revised SPMP regulations were issued on Nov. 12, 1985, superseding any previous regulations and policy guidelines by the Health Care Financing Administration (now CMS) or its predecessor agency. 42 *Code of Federal Regulations (CFR)* 432.2 defines directly supporting staff, skilled professional medical personnel and staff of other public agencies. Section 432.45 specifies that the enhanced FFP is not available for state personnel who conduct survey activities and certify facilities for Medicaid participation.

Section 432.50, in part, specifies that 75% FFP is available for staffing and training costs of SPMP and directly supporting staff of the Medicaid agency of other public agencies and that the allocation of their costs must be based on either the actual percentages of time spent carrying out duties in the specified areas or another methodology approved by HCFA.

Section 432.50(d)(1)(i-v) delineates other limitations on FFP, including a definition of professional education and training. And lastly, 42 *CFR* 433.15 states that 75% FFP is available for compensation and training of SPMP and staff directly supporting them if all criteria in 432.50 (c) and (d) are met. (Please refer to the Appendix for the text of these regulations.)

Criteria for Determining SPMP

There are seven specific criteria that must be satisfied. They are:

(1) The expenditures that qualify for enhanced FFP are salary or other compensation, fringe benefits, travel, per diem and training of SPMP and their directly supporting staff when they are performing activities that are directly related to the administration of the Medicaid program. Operating expenses (e.g., rent and supplies) and indirect costs charged directly or allocated to these personnel qualify for 50% FFP.

(2) SPMP have professional education and training in the field of medical care or appropriate medical practice. This is defined as completion of a two-year or longer program leading to an academic degree or certificate in a medically related profession, demonstrated by possession of a medical license, certificate or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization.

The medical license or certificate must document the minimal two-year professional education and training requirement. In other words, an individual with a certificate or license (such as a licensed practical nurse) does not automatically qualify as an SPMP if s/he has not completed the requisite two-year degree program in the field of medical care.

The a recent financial review guide issued by CMS mentions using the "American Universities and Colleges" reference guide, compiled by the American Council on Education, to check on degree fields considered medical in nature (those listed under "Health Professions") and whether a college or university is certified by a professional medical organization.

Several Departmental Appeals Board decisions have discussed SPMP status by professional degree and license as part of their rulings in a particular case. These discussions are summarized below:

> Psychology. The Review Guide notes that the Departmental Appeals Board (DAB), in Decision No. 1033, determined that a Ph.D. in psychology together with a State license to practice as a psychologist meets the educational limitation for SPMP status.
>
> Medical Social Work. According to the Review Guide, the issuance of DAB decisions on medical social work prompted the federal agency to "rethink policy regarding professional education requirements." The threshold for for social workers to qualify as SPMP is "'…if their education (including training received as part of academic work) specifically included the health care and/or medical applications of the social work field.' Work experience or on-the-job training could not be substituted for meeting the educational requirements."
>
> State agencies must show that social workers' education and training in social work specifically includes health care and/or medical applications. The Review Guide notes that States should use graduate level concentrations, or specializations or tracks, as defined by various MSW programs, to identify those social workers that would be eligible for the enhanced rate.

CMS also recommends that States demonstrate an "education equivalency" for every social worker being claimed as SPMP where the schools they attended do not offer medical or health concentrations, or where they are offered but the social worker did not compete one.

CMS laid out guidelines for its auditors to use when reviewing MSWs being claimed as SPMP. State agencies must show that each social worker has an MSW degree, and as part of the course work for the master's degree, a specialization (track or concentration) in clinical practice, health care practice, other medical application, or its equivalent.

The CMS Financial Review Guide specifies the equivalency standards, as follows:.

a) Completion of a graduate degree at a school that offered health care or medical specializations but the social worker formally concentrated in another area. The social worker would qualify if he/she completed as many health courses as would be required for a concentration in health care.

b) If the applicable graduate program offers concentrations, but none distinctly in health care or medical applications, the transcript must show at least as many credits received in health care as would be required for any of the concentrations offered. For example, if a minimum of four courses is required for any concentration, the transcript must show completion of at least four courses in health or medical applications.

c) If the applicable MSW program did not offer concentrations at all, the transcript must show more credits received in health care or medical applications than in any other specialized area of study.

No amount of on-the-job experience in a Medicaid agency or any other job or employment situation can be substituted for professional education and training."

In these earlier DAB decisions, it was clear that states needed to distinguish between medical social workers and individuals with an MSW degree without a medical or health focus. The DAB, in its findings, considered the education/training of individual social workers. It stressed that having medical coursework or courses with medical application of social work, including field work in a health or medical setting, was the standard, and that on-the-job training or work experience did not apply. The DAB, however, refrained from establishing the actual courses or numbers of courses that qualified, but rather considered these on an individual basis.

A later DAB decision in West Virginia (Decision No.1434) in 1993 mentioned the CMS standard of a medical or health care concentration. However, it did not specifically apply this standard when reviewing individual social workers in this appeal; the DAB again looked at courses and field placements with a medical/health care content.

The Review Guide's use of the medical or health care concentration as the criterion, or alternative "education equivalency" requirements, narrows the definition of SPMP status for social workers.

The "concentration" and "equivalent education" standards were applied in a 2004 Office of the Inspector General (OIG) audit of SPMP payments received by the West Virginia Bureau for Medical Services. The OIG recommended a refund of claims for social workers that did not have a master's degree in social work or had a master's degree but the State did not have documentation that the graduate course work included the required specialization [in clinical practice, health care practice, other medical application, or its equivalent].

(3) SPMP must be in positions that have duties and responsibilities that require those professional medical knowledge and skills. The function performed by the SPMP must require that level of medical expertise to be performed effectively. The primary evidence of this would be position descriptions, job announcements or job classifications.

The Review Guide states that the reviewer may also want to establish whether the position is listed in a handbook or dictionary of occupational titles as an appropriate medical classification (such as the Occupational Outlook Handbook, Bureau of Labor Statistics, U. S. Department of Labor or the Standard Occupational or the "standard Occupational Classification Manual," National Technical Information Service, U. S. Department of Commerce).

Examples of functions that would meet the "functional" criteria include, but are not limited to, the following:

- Acting as a liaison on the medical aspects of the program with providers of services and other agencies that provide medical care.
- Furnishing expert medical opinions for the adjudication of administrative appeals.
- Reviewing complex physician billings.
- Providing technical assistance and drug abuse screening on pharmacy billings.
- Participating in medical review or independent professional review team activities.
- Assessing the necessity for and adequacy of medical care and services provided, as in utilization review.
- Assessing, through case management activities, the necessity for and adequacy of medical care and services required by individual recipients. (Excluded is case management provided under an approved HCBS waiver.)

The Review Guide also listed functions which do not require professional medical expertise and therefore do not qualify for 75% FFP. CMS notes in the Guide that this list is not all inclusive.

- Accounting and auditing
- Budgeting
- Program management for categories of services not requiring medical expertise: emergency transportation, non emergency transportation, and home and community-based waiver services.
- Program analysis where the emphasis is cost or utilization of services in lieu of the medical aspects of the program.

- Cost reimbursement including all analytical work, related to the program cost of covered services, cost report settlement, and establishment of rates.
- Program integrity including any investigation and follow-up activities not directly involving the determination of the medical necessity of specific services.
- Third party liability activities/overpayment collection activities.
- Administrative practices and procedures including the development of State plans, administrative rates, cost allocation and provider agreements.
- All claims processing activities except…IS THIS DONE?
- EPSDT, including all outreach activities such as notifying clients of required screens from a periodicity schedule, scheduling appointments, informing clients and arranging transportation.
- Eligibility determination
- Legal services including administrative appeals.
- Contract management.

FFP would be available at 50% for an otherwise qualified SPMP performing a function which is unrelated to the specialized field of medical care and requires no skilled medical training. Time spent by a qualified SPMP on supervisory related administrative functions such as personnel, staff meetings, counseling, etc., would be allowable at 50% FFP. When a team performs an SPMP function (e.g., medical review team), each individual team member must qualify as an SPMP to claim his/her time at the enhanced rate.

(4) A state-documented employer-employee relationship must exist between the Medicaid agency (or any other public agency) and the SPMP and directly supporting staff. .

The federal interpretation here is that the personnel are under the State's merit personnel system in all aspects as documented by the State's personnel and payroll system and records. For the most part, 75% FFP is not allowed for contractors with private organizations or independent contractors. In situations where the Medicaid agency (or any other public agency) contracts directly for personal services as a common method of securing services of an SPMP, it must demonstrate that a documented employer-employee relationship exists directly between them and the Medicaid agency (or any other public agency). The Review Guide tells its reviewers to examine the substantive relationship between the parties on a case-by-case basis. The standard laid out in the Guide follows:

> "Generally, if the substantive relationship specified in the contract indicates that the Medicaid agency or any other public agency has control over when, where, and how the contractor works, we would allow this level of control to indicate that a documented employer-employee relationship exists, even though that person may no be under the State's merit personnel system as documented in the personnel and payroll record systems of the State."

It does not include employees of a State's fiscal agent or other contractor, who may contract with or employ SPMPs directly. These contracts would be reimbursed at only 50% FFP.

(5) Directly supporting staff are secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that are directly necessary for the completion of the professional medical responsibilities and functions of the skilled professional medical staff. The skilled professional medical staff must directly supervise the supporting staff and the performance of the supporting staff's work.

The Review Guide notes that "support staff" is defined in the congressional reports as "clerical staff," who are interpreted to be those mentioned in the previous paragraph. The Guide notes that other sub professional staff, such as administrative and management assistants, statistical or accounting clerks, office managers, technicians, cannot be claimed at the enhanced rate, if they provide support to SPMPs.

There must be documentation or other evidence that the "direct support" (defined as clerical services, such as typing, filing, copying, preparing correspondence, preparing records and other general office work) is directly related and necessary to the completion of the professional medical functions of the SPMP. The SPMP must be immediately responsible for the work performed by the clerical staff and must directly supervise (immediate first-level supervision) the supporting staff and the performance of that staff's work. The best evidence of this, according to the Review Guide, would be that the SPMP is responsible for the supporting staff's performance appraisal.

Enhanced (75%) FFP is allowed only for that portion of the clerical time related to the performance of the SPMP's skilled medical functions.

(6) The rate of 75% FFP is available for SPMP and directly supporting staff of other public agencies if all of the applicable criteria in items 1-5 are met and the public agency has a written agreement with the Medicaid agency to verify that those requirements are met.

Where SPMP and directly supporting staff employed by pubic agencies other than the Medicaid agency assist in the administration of the Medicaid program, they can get 75% FFP for the costs of salary or other compensation, benefits, travel, per diem and training as long as there is a written interagency agreement specifying that the staff and their functions meet the applicable criteria.

The agreement should also spell out the "directly related" duties that the other public agency will perform—those necessary to the operation of the Medicaid program. An entity is considered public if it is part of State and local government and subject to supervision and control of a governmental unit; the receipt of Federal funding does not in itself bestow public status to a private agency.

(7) FFP must be prorated for split functions for SPMP and directly supporting staff.

Only the portion of an individual's working time that is spent in performing SPMP duties can be reimbursed at 75% FFP. Where the SPMP and directly supporting staff spend less than 100% of their time in SPMP functions, their costs must be allocated among all functions, based on actual time spent in each function or another approved methodology. According to the Review Guide, CMS accepts current timesheets kept by the SPMP personnel or some form of sampling methodology. Proration is needed when an SPMP is also a supervisor performing general administrative functions that must be claimed at 50% FFP.

MEDICAID ADMINISTRATIVE CLAIMING PROGRAM
SUMMARY OF PROPOSED ACTIVITY CODES FOR LOCAL HEALTH JURISDICTIONS

	MER	Used by All Staff (Non-enhanced 50% match)	Skilled Professional Medical Skills Needed (Enhanced 75% match)	Non-Matchable Activities
Medicaid Service Delivery				**1** – Billable Services, Direct Patient Care
Non-Medicaid Services				**2** - Non-Medicaid, Other Program or Social Service Activities
Outreach	**100%**	**3** - Medicaid Outreach **5** - Facilitating Medicaid Eligibility Determinations		**4** - Non-Medicaid Outreach **6** - Facilitating Eligibility for Non-Medicaid Programs
Linkage	**MER**	**8** - Referral, Coordination & Monitoring of Medicaid Services	**9A** - SPMP Care Management **9B**– SPMP Anticipatory Guidance	7 – Referral, Coordination & Monitoring of Non-Medicaid Services
Oral Health Outreach and Linkage for Medicaid Children	**100%**	**10 –** Outreach and Access to Oral Health Care for Medicaid Children		
Arranging Medicaid Transportation	**100%**	**12** – Arranging Transportation for Medicaid Services		**13 –** Transportation for Non-Medicaid Services
Interpretation (DSHS Interpreter Services Program)		* **(Interpreter Services Program only)** * Must be performed by a certified, qualified interpreter		
for Medicaid Services	**100%**	**14 –** Interpretation for Medicaid Services*****		**17** - Interpretation for Non-Medicaid services
for Medicaid-related Outreach	**100%**	**15 –** Interpretation for Medicaid-related Outreach Services*		
for Medicaid-Related Linkage	**MER**	**16 –** Interpretation for Medicaid Related Linkage Activities*		
Vaccine Quality Improvement	**MER**	**18** – Vaccine Quality Improvement/CHILD Profile	**9F** – SPMP Vaccine Quality Improvement	
Community Resource Development, Systems Planning and Interagency Coordination	**MER**	**19** – Community Resource Development, Systems Planning, and Interagency Coordination of Medicaid Services	**9C** - SPMP Interagency Coordination **9D** – SPMP Training to Improve Matchable SPMP Activities **9E** – SPMP Internal Quality Management	**20** – Community Resource Development, Systems Planning and Interagency Coordination of Non-Medicaid Services **11 –** Training to improve skills in non-Medicaid services
Provider Relations		**21**- Medicaid Provider Relations		**22** – Non Medical Provider Relations
Management of Medicaid Administrative Claiming activities	**100%**	**23**- Medicaid Administrative Claiming documentation and claims administration **24** - MAC Implementation Training		
General time allocated to all activities		**25** - General Administration **26** - Paid Time Off **27** – Time Not Scheduled to Work		

MEDICAID ADMINISTRATIVE MATCH CLAIMING PROGRAM
PROPOSED ACTIVITY CODES FOR LOCAL HEALTH JURISDICTIONS

CODE 1: DIRECT PATIENT CARE
MER: Not applied; non-matchable activity

All staff may use this code.

Providing client care, treatment and/or counseling services to an individual in order to correct or ameliorate a specific condition. Includes the provision of direct services reimbursed through Medicaid, as well as direct services that are not reimbursed by Medicaid. Includes paperwork, clerical activities, oral or written interpretation furnished by the direct patient care provider, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Direct clinical/treatment services including scheduling, collecting medical history, performing assessment/medical exams, charting, and patient education that is part of a routine office visit;
- Health screenings and diagnostic evaluations (e.g., orthopedic evaluation, vision screen, and audiological testing services);
- Screening and treating communicable diseases (e.g., STDs, HIV, TB);
- Counseling/therapy services;
- Skills training for medical/dental/mental health services;
- Administering first aid, emergency care, medication or immunizations/vaccines;
- Preparing for and cleaning up after screening or medical procedures;
- Submitting billing documents for patient care;
- Performing specialty clinic examinations;
- Performing pregnancy tests;
- Developmental assessments;
- Providing smoking cessation and/or breastfeeding education for pregnant women;

CODE 2: NON-MEDICAID OTHER PROGRAM AND SOCIAL SERVICE ACTIVITIES
MER: Not applied; non-matchable activity

All staff may use this code.

This code should be used when performing any non-health-related or non-Medicaid direct service activities, such as education, employment, job training, social services and other activities or services. Includes activities unrelated to the administration of the Medicaid program. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Developing funding proposals for non-Medicaid services;
- Teaching first aid or CPR classes;
- Teaching individuals and their family members ways to improve or maintain their health status (e.g. nutrition, physical activity, weight reduction);
- Purchasing food, clothing or other supplies for a client;
- Investigating communicable diseases;
- Providing DSHS with information about policies governing the WIC program;

- Providing non-medical/dental/mental health technical assistance and monitoring of local programs;
- Preparing for and attending court appearances and any court-related activity.

CODE 3: MEDICAID OUTREACH
MER: 100%

All staff may use this code.

A campaign, program or ongoing activity targeted to 1) bringing potential eligibles into the Medicaid system for the purpose of determining eligibility or 2) bringing Medicaid eligible individuals into specific Medicaid services. Activities may include informing Medicaid eligible or potentially eligible individuals, agencies, and community groups about the range of health services covered by the Medicaid program including preventive or remedial health care services offered by the Medicaid program that may benefit them. Oral or written informing methods may be used. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Use this code when conducting outreach campaigns directed to the entire population to encourage potentially Medicaid eligible individuals to apply for Medicaid and outreach campaigns directed toward bringing Medicaid eligible individuals into Medicaid covered services, such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Medicaid prenatal care, a Medicaid medical home, etc.

A health education program or campaign may be allowable as a Medicaid outreach activity, if it is targeted specifically to Medicaid services and for Medicaid eligible individuals, such as an educational campaign on immunization addressed to parents of Medicaid eligible children. Health education programs or campaigns or component parts of health education programs or campaigns that are general in nature such as oral hygiene education programs, car passenger safety, or antismoking programs should not be recorded to this code.

Report under this code only that portion of time spent in activities that specifically address Medicaid outreach. Report the non-Medicaid portion of these outreach campaigns for Code 4 (for example, general health education programs such as car passenger safety, lice control, etc).

Examples of activities reported under this code include:

- Providing information to the general population about the Medicaid program to encourage potential Medicaid eligibles to apply for Medicaid; explaining the benefits of health coverage through Medicaid;
- Providing outreach to low-income individuals and communities regarding the availability of Medicaid coverage, including coverage for children living alone or in families with family income at or below 200% of the federal poverty income guidelines, and to pregnant and parenting teens.
- With MAA staff assistance, training providers about managed care in general and about specific services to high need groups such as Supplemental Security Income (SSI) eligibles, children, and pregnant women.
- Providing information to individuals, families, agencies and community groups about Medicaid managed care plans and about the Medicaid covered services they offer for the purpose of bringing Medicaid eligibles into Medicaid health care services;
- Assisting Medicaid recipients eligible for *Healthy Options* to select a contracted carrier and a Primary Care Provider within that carrier; assist in helping them to understand

enrollment and assignment procedures and how to request change in carrier or PCP, file a complaint or grievance, request a fair hearing, or enroll new members of household; assist them to access their managed care providers and Medicaid services not covered by their plans; includes trouble-shooting on behalf of a recipient;

- Provide outreach to and contact with clients to help them understand managed care and how to use it, including Health Options enrollment, assignments, and trouble shooting;
- Informing families with children about the availability of Medicaid services, such as Early Periodic Screening, Diagnosis and Treatment, and how to enroll in Medicaid;
- Identifying medically at-risk, potentially eligible individuals who may benefit from participating in Medicaid services;
- Making referrals, scheduling and following up on EPSDT screens, interperiodic screens and appropriate immunizations;
- Arranging for and following up on any diagnostic or treatment services, which may be required as the result of a condition identified during the child's EPSDT screen.

CODE 4: NON-MEDICAID OUTREACH
MER: Not applied; non-matchable activity

All staff may use this code.

Use when informing individuals about social, educational, legal or other services not covered by Medicaid and how to access them. Also use when conducting general health education programs addressed to the general population. Oral or written methods may be used. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Conducting outreach activities that inform individuals about non-Medicaid health programs and services (e.g., car passenger safety);
- Conducting general health education programs or campaigns addressed to the general population (e.g., dental hygiene, antismoking, alcohol reduction, victim assistance and domestic violence);
- Scheduling and promoting activities that educate individuals about the benefits of healthy lifestyles and practices;
- Providing information about child care resources;
- Conducting outreach campaigns that encourage persons to access social, educational, legal or other services not covered by Medicaid such as clothing, food, child care, TANF, food stamps, WIC, Head Start, legal aid, housing, jobs, etc.

CODE 5: FACILITATING MEDICAID ELIGIBILITY DETERMINATIONS
MER: 100%

All staff may use this code.

Use this code when assisting an individual in becoming eligible for Medicaid. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

This activity does **not** include the actual Medicaid eligibility determination.

Examples of activities reported under this code include:

- Explaining eligibility rules and the eligibility process for *Healthy Options* and other Medicaid programs to prospective applicants;
- Making referrals to encourage individuals who are potentially eligible to apply for Medicaid or Healthy Start;
- Gathering information related to the Medicaid application and eligibility determination (or redetermination) from an individual, including resource information and third party liability (TPL) information, in preparation for submitting a formal Medicaid application;
- Assist families seeking Medicaid coverage only for their children in forwarding the Medicaid application and supporting documentation to the Medicaid Eligibility Determination Services (MEDS) office for processing;
- Referring families applying for other types of public assistance to the DSHS community service office to apply for Medicaid benefits for themselves or their children;
- Providing or packaging necessary Medicaid forms needed for the Medicaid eligibility determination.

CODE 6: FACILITATING ELIGIBILITY FOR NON-MEDICAID PROGRAMS
MER: Not applied; non-matchable activity

All staff may use this code.

Use when assisting an individual to become eligible for non-Medicaid programs, such as TANF, food stamps, SSI, WIC, Section 8 housing, etc. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Informing individuals about programs such as cash assistance, food stamps, WIC, day care, legal aid, and other social and educational programs and referring them to the appropriate agency to make an application;
- Explaining eligibility rules and the eligibility process for non-Medicaid programs, such as food stamps, TANF, WIC, SSI, etc., to prospective applicants;
- Assisting an individual to complete an application for a non-Medicaid program such as food stamps, TANF, WIC, SSI, etc.;
- Gathering information related to the application and eligibility determination for non-Medicaid programs from a client;
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

CODE 7: REFERRAL, COORDINATION AND MONITORING OF NON-MEDICAID SERVICES
MER: Not applied; non-matchable activity

All staff may use this code.

Use when performing referrals, coordinating, and/or monitoring the delivery of social, educational, legal, or other services not covered by Medicaid. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Making referrals for and coordinating access to social and educational services such as child care, employment, job training, clothing assistance, and housing;
- Making referrals for, coordinating and monitoring the delivery of school and/or community based health screens (vision, hearing, scoliosis);
- Gathering information from individuals to determine the kinds of social services that may be needed;
- Providing information to another provider about non-medical services being provided to an individual;
- Providing follow up to ensure whether individuals received social services such as housing, income assistance, domestic violence services, after school services, and child care.

CODE 8: REFERRAL, COORDINATION AND MONITORING OF MEDICAID SERVICES
MER: MER applied

All staff may use this code.

Medicaid providers should use Code 1 when conducting any screening, referral, coordination and monitoring that are part of a routine office visit or a First Steps or Targeted Case Management visit and reimbursed as part of the Medicaid program.

Use when performing referral, linkage, coordination, and monitoring activities that facilitate access to and coordination of Medicaid covered services. Includes identifying the need for and types of medical care an individual needs, making referrals to Medicaid providers, and doing follow up or monitoring to assess individual's progress. Include consultation with other providers to access Medicaid services for a client. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Gathering information that may be required to make referrals for medical health, mental health, or substance abuse services and assisting individuals in obtaining these services;
- Identifying and referring individuals who may be in need of Medicaid family planning services (when the agency does not directly provide comprehensive clinical medical family planning services and supplies);
- Assisting with arrangements for specialty care;
- Making referral, coordinating, and following up on scheduled medical or physical examinations and necessary medical/dental mental health evaluations;
- Working with children, their families, other staff and providers to identify, arrange for, and coordinate services covered under Medicaid that may be required as the result of screens, evaluations or examinations;
- Referring individuals for necessary medical health, dental, mental health or substance abuse services;
- Assisting families of medically fragile children to establish a "medical home" and to access other necessary medical/dental/mental health services;
- Providing follow-along activities that ensure high-risk populations (e.g., substance abusing pregnant women or new mothers, frail elderly, individuals with tuberculosis, etc.) achieve positive health outcomes;

- Participating in case conferences or multi-disciplinary teams to review an individual's health-related needs and plans and to coordinate medical and health-related care and services;
- Participating in consultation to individuals to assist them in understanding and identifying health problems or conditions and in recognizing the value of preventive and remedial health care. **(This activity may be claimed only when it is not part of a standard medical exam or when it is not billed as a Medicaid service.)**

CODE 9: SPMP MEDICAL CARE COORDINATION
MER: MER applied

Medicaid providers should use Code 1 when conducting any screening, referral, coordination and monitoring that are part of a routine office visit, a First Steps visit, or a Targeted Case Management visit and reimbursed as part of the Medicaid program.

Only staff who are Skilled Professional Medical Personnel (SPMP) may use this code when their skilled professional medical education and training are required to perform the activity.

Skilled professional medical care coordination facilitates access and use of Medicaid covered services when the needs of the individual are medically complex, and professional expertise is needed to assist the individual to access care or treatment. Includes assessing the need for and types of medical care required by individual Medicaid beneficiaries and consultation with other medical providers around the need for and adequacy of an individual's care or treatment. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Activities reported under this code include the following sub-categories:

- Code 9A: SPMP c*are management to assess need for and adequacy of medical care services, including related consultation with individuals and medical providers,* when not part of a medical visit or other Medicaid billable service. Case management being provided through an approved Home and Community-Based Services waiver must be claimed at the appropriate FMAP rate as a medical assistance expenditure even if the services are performed by a qualified SPMP.
- Code 9B: *Anticipatory guidance to facilitate medical care and treatment for complex health need. Includes* preparing for, coordinating or providing information about growth and development and the prevention of injury, disease, and/or disability;
- Code 9C: Participation in state, county, or community *interagency meetings, including meetings with medical providers, to improve the medical aspects of Medicaid services, or to plan or monitor the delivery of Medicaid-covered medical servi*ces;
- Code 9D: SPMP training to improve the skill levels of SPMP staff in performing allowable SPMP activities;
- Code 9E: *Internal quality management* by SPMP only when performing Medicaid-related quality management activities such as utilization review, ongoing evaluation, and development of standards and protocols.
- Code 9F*: SPMP Vaccine Quality Improvement* activities performed by Skilled Professional Medical Personnel that oversee and coordinate the medical aspects of vaccine programs in local health jurisdictions. Includes developing and monitoring of clinical protocols for storage and handling of vaccine to ensure their quality. Includes clinical monitoring of the handling and distribution of vaccines. Includes site reviews to ensure the medical quality of vaccine administration and of the medical protocols used in vaccine programs. Includes providing and exchanging medical information to or with medical providers to ensure the overall quality of vaccine programs – appropriate uses and dosages, adverse effects, interpretation of medical

guidelines, epidemiology, standards of care, and other clinical concerns. Includes recommendations to medical providers to maintain quality vaccine programs, such as handling vaccine storage and administration incidents, such as whether to continue use of vaccine not properly refrigerated and whether to recommend revaccination. Administering immunizations/vaccines and other direct medical care should be reported to Code 1: Direct Patient Care.

CODE 10: OUTREACH AND ACCESS TO ORAL HEALTH CARE FOR MEDICAID CHILDREN
MER: 100%

Use when recruiting providers to accept Medicaid children into dental care and performing outreach to link Medicaid children 0 - 18 years into timely oral health care.

Examples of activities reported under this code include:

- Outreach targeting dental and medical providers, community agencies, media and potential clients.
- Referring Medicaid enrolled children aged 0-5 to the ABCD dental program.
- Referring Medicaid enrolled children aged 0-18 to oral health care.
- Development and maintenance of an information clearinghouse & referral/resource information on the availability of dental care for Medicaid children, including the ABCD program.
- Client orientation sessions within the community to reduce barriers and improve client behavior and program participation.
- Assessment of client and provider satisfaction.

CODE 11: TRAINING TO IMPROVE SKILLS IN DELIVERY OF NON-MEDICAID SERVICES
MER: Not applied; non-matchable activity

Use when providing or receiving training that improves skills in delivering non-Medicaid services. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

CODE 12: ARRANGING TRANSPORTATION FOR MEDICAID SERVICES
MER – 100%

All staff may use this code.

Use when assisting an individual enrolled in Medicaid to access transportation services covered by the DSHS Medicaid transportation brokerage system. Assisting individuals to arrange transportation to Medicaid services, including Healthy Kids examinations. Educating clients on the Medicaid interpretation or transportation brokerage system. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

CODE 13: ARRANGING TRANSPORTATION FOR NON-MEDICAID SERVICES
MER: Not applied; non-matchable activity.

Use when assisting Medicaid or non-Medicaid clients to access services not covered by Medicaid by arranging, scheduling or providing transportation, including accompanying the individual to a service not covered by Medicaid. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

CODE 14: INTERPRETATION FOR MEDICAID-COVERED MEDICAL SERVICES
MER – 100%

This code is to be used only by those agencies that have a contract with the Interpreter Service Program at DSHS. Staff or contractors who are certified and/or qualified by DSHS or a Local Health Jurisdiction to furnish interpreter services may use this code.

Use when providing interpreter services as part of a Medicaid-covered medical service. Includes paperwork, clerical activities, staff travel, or training directly related to performing this activity.

CODE 15: INTERPRETATION FOR MEDICAID-RELATED OUTREACH ACTIVITIES
MER: 100%

This code is to be used only by those agencies that have a contract with the Interpreter Service Program at DSHS. Staff or contractors who are certified and/or qualified by DSHS or a Local Health Jurisdiction to furnish interpretation services may use this code.

Use when interpreting information about the Medicaid program to eligible or potentially eligible individuals or families, or providing information on the Medicaid program to communities, including written translation of outreach materials. Includes paperwork, clerical activities, staff travel, or training directly related to performing this activity.

CODE 16: INTERPRETATION FOR MEDICAID-RELATED LINKAGE ACTIVITIES
MER: MER applied

This code is to be used only by those agencies that have a contract with the Interpreter Service Program at DSHS .Use when assisting an individual to access Medicaid-covered services. Includes paperwork, clerical activities, staff travel, or training directly related to performing this activity.

Interpretation services furnished by a direct patient care provider (e.g., speech therapist, nurse, physician) during a direct patient care visit should be reported to Code 1, unless the interpreter is certified or qualified by DSHS or the Local Health Jurisdiction. In this situation, the interpreter would use Code 14.

Non-Medicaid interpretation services should be reported under Code 17.

CODE 17: INTERPRETATION FOR NON-MEDICAID SERVICES
MER: Not applied; non-matchable activity

All staff may use this code.

Interpretation services furnished by a direct patient care provider (e.g. nurse, physician) during a direct patient care visit should be reported to Code 1. Use this code when assisting an individual to access non-Medicaid services through arranging, obtaining or providing interpretation services. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Scheduling or arranging transportation to social, vocational, and/or educational programs;
- Arranging transportation for a pregnant woman to WIC appointments;
- Arranging for or providing interpretation services (oral and/or signing services) that assist the individual to access and understand social, educational, and vocational services;
- Developing translation materials that assist individuals to access and understand social, educational, and vocational services.

CODE 18: VACCINE QUALITY IMPROVEMENT/CHILD PROFILE
MER: MER applied

All staff may use this code.

Use when performing activities that do not require skilled professional medical education or training to administer or support the vaccine quality improvement program. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities. Administering immunizations/vaccines and other direct medical care should be reported to Code 1: Direct Patient Care.

Examples:

- Data entry related to Child Profile, the State immunization registry. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.
- Routine administrative functions related to ordering and distributing vaccines – filling and tracking orders, distributing vaccines, developing provider agreements, coordinating and performing monthly count of available vaccines, assisting providers to complete the monthly count, and preparing monthly vaccine reports.
- Routine administrative functions related to storing vaccines – tracking vaccine inventory by vaccine type, dose, and manufacturer lot number, package and handling of vaccine.
- Overseeing the contracts and accounting of doses of federally and state-supplied vaccine.
- Conducting routine quality assurance activities such as monitoring of refrigeration temperature logs.

CODE 19: COMMUNITY RESOURCE DEVELOPMENT, SYSTEMS PLANNING AND INTERAGENCY COORDINATION OF MEDICAID SERVICES
MER: MER applied

All staff whose job descriptions or duty statements include responsibilities for community resource development, systems planning and interagency coordination around Medicaid services may use this code. Includes planning and development of services, programs and resources that

relate to Medicaid covered medical/dental/mental health/chemical dependency services, such as the development of policy, procedures and protocols for the delivery and coordination of care to individuals. Use this code for collaborative activities that involve planning and resource development around Medicaid services with other agencies, which will improve the availability and quality of medical/dental/mental health services and the cost-effectiveness of the health care delivery system. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Working with other agencies providing Medicaid services to improve the coordination and delivery of services, to expand their access to specific populations of Medicaid recipients, and to improve collaboration around the early identification of medical/dental/mental health/chemical dependency problems;
- Assessing the capacity of the agency and its providers to deliver accessible Medicaid covered medical/dental/mental health/chemical dependency assessment, treatment and care services to Medicaid eligibles and identifying potential barriers and needs;
- Assessing the capacity of providers to deliver Medicaid covered health assessment, preventive health services and medical care;
- Reducing overlaps and duplication in Medicaid services, and closing gaps in the availability of services, especially for children;
- Streamlining referral system to improve client access to Medicaid-covered medical services;
- Working with Healthy Options Plans and participating in community assessment/planning processes to increase network capacity and reduce barriers to care;
- Active participation on Healthy Options oversight committees within respective communities;
- Working with managed care plans and pediatric health professionals on improving childhood immunization rates;
- Planning programs and services to meet the identified needs of high-risk populations of Medicaid eligibles served by the agency and its providers;
- Interagency coordination to improve the delivery of Medicaid services;
- Collecting and analyzing Medicaid data related to population group or geographic areas, including data gathered from chart reviews, in order to improve service coordination and delivery;
- Conducting needs assessments related to medical/dental/mental health services including Medicaid services within a community, such as identifying the need for and working with local providers to expand prenatal and obstetric services to Medicaid eligible individuals or ensuring that residents in a community where a Medicaid provider(s) is closing or leaving have ongoing access to medical care;
- Developing plans for expansion of Medicaid-covered services;
- Coordinating efforts to improve access to Medicaid covered medical/dental/mental health services to specific populations or geographic areas that are under-served.

CODE 20: COMMUNITY RESOURCE DEVELOPMENT, SYSTEMS PLANNING AND INTERAGENCY COORDINATION OF NON-MEDICAID SERVICES
MER: Not applied; non-matchable activity

All staff may use this code.

Use when performing activities associated with the development of strategies to improve the coordination and delivery of non-medical services, including educational, social, vocational, and other services and when performing collaborative activities with other agencies. Includes paperwork, clerical activities, related staff travel or training.

Examples of activities reported under this code include:

- Identifying gaps or duplication of other non-medical services (e.g., social, vocational, and educational programs) and developing strategies to improve the coordination;
- Evaluating the need for non-medical services in relation to specific populations or geographic areas;
- Analyzing non-medical data related to a specific program, population or geographic area of these services; Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.
- Planning, developing, conducting and/or attending training that promotes general community collaboration and developing non-medical services in the community;
- Developing interagency policies and procedures for non-medical programs and services;
- Participating in interagency or community planning efforts to close gaps in social services such as housing, childcare, and after school programs;
- Writing proposals for non health care services such as smoking cessation and domestic violence;
- Conducting external relations (e.g. site visits to police departments, domestic violence services, nutrition programs);
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services.

CODE 21: MEDICAID PROVIDER RELATIONS
MER: MER applied

All staff may use this code.

Use this code when performing activities to secure and maintain the pool of eligible Medicaid (medical/dental/mental health) providers. Use this code when working with staff of Healthy Options managed care plans to ensure access to and availability of service for clients enrolled in them. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Recruiting new medical/dental/mental health providers to accept and serve Medicaid eligible individuals and assist Medicaid eligibles to keep scheduled appointments; assist with arrangements for specialty care;
- Providing information and technical support to providers on medical policy and regulations;
- Working with providers/carriers to assist them in development of working relationships within respective communities;

- Developing medical service/provider directories for those who provide services to targeted population groups e.g., EPSDT children, pregnant women;
- Providing technical assistance and support to providers;
- Working with medical resources, such as managed care plans, to locate and develop health services referral relationships;
- Monitoring effectiveness of programs providing Medicaid-covered services, including client satisfaction surveys for medical/dental/mental health services;
- Contracting with local agencies for the provision of Medicaid services or Medicaid administrative match activities; monitoring to ensure compliance with the terms of the contract, their capacity and availability.
- Developing future referral capacity with specialty medical care providers by discussing medical health programs, including client needs and service delivery requirements.

CODE 22: NON-MEDICAL PROVIDER RELATIONS
MER: Not applied; non-matchable activity

All staff may use this code.

Use when performing activities related to securing and maintaining non-health related providers. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Recruiting non-medical providers, (e.g., child care, domestic violence, food pantry);
- Recruiting with outside agencies regarding social and education programs, for example agencies that assist with childcare and housing assistance;
- Providing technical assistance and support to new non-medical staff, including orientation;
- Contracting with local agencies for the provision of non-Medicaid services; monitoring to ensure compliance with the terms of the contract, their capacity and availability.
- Developing staff directories;
- Developing non-medical referral sources.

CODE 23: MEDICAID ADMINISTRATIVE CLAIMING COORDINATION AND CLAIMS ADMINISTRATION
MER: 100%

Reserved for use by individuals in local health departments with designated responsibilities for managing components of the Medicaid administrative match program - the time surveys the invoice, or overall program administration**.**

CODE 24: MAC IMPLEMENTATION TRAINING
MER: 100%

All staff may use this code.

Use when participating in MAC training or filling out MAC time survey, or when giving or attending training that improves skills of SPMP and non-SPMP staff to perform outreach and linkage to the Medicaid program and the services it covers.

CODE 25: GENERAL ADMINISTRATION
MER: Not applied; reallocated proportionately to other activities

All staff may use this code.

Performing general administrative activities (i.e., those that are not specific to any identified function or that relate to multiple functions of the agency).

Examples of activities reported under this code include:
- Attending or facilitating general agency or unit staff meetings or board meetings;
- Developing and monitoring agency or program budgets;
- Providing general supervision of staff and employee performance reviews;
- Processing payroll/personnel-related documents;
- Maintaining inventories and ordering supplies;
- Reviewing or writing agency, departmental or unit policies and procedures;
- Conducting health promotion activities for staff;
- Providing or attending training related to professional development;
- Providing or attending general in-services or training, including new employee orientation or supervision or computer training;
- Earning compensatory time off;
- Paid overtime;
- Paid breaks.

CODE 26: PAID TIME OFF
MER: Not applied; reallocated proportionately to other activities

All staff may use this code.

Any employee time off that is paid, such as paid vacation, paid sick leave, paid holiday time, or paid jury duty. This does NOT include breaks or earning compensatory time off (see Code 25).

CODE 27: TIME NOT SCHEDULED TO WORK
MER: Not applied

All staff may use this code.

Used when not scheduled to work in the claiming unit or when working in a program whose costs are not included in the claim.

Code	Scenario
1 – Direct Patient Care (Providing care, treatment and counseling services)	*Activity*: A nurse makes a Maternal Support Services (MSS) home visit to a postpartum mother and her infant. Takes infant's height/weight, assists mother with a dental referral, and does charting after the visit. *Explanation*: MSS is a direct service covered by Medicaid. Charting for a patient care visit is also part of direct patient care. This time should all be reported as Code 1.
2 – Non-Medicaid, Other Program and Social Service Activities	*Activity*: A social worker prepares to teach a parenting class. *Explanation:* Preparing for and teaching parenting classes (and other education classes on healthy lifestyles or general health maintenance, such as CPR or weight reduction), should be reported as Code 2. Parenting education is not a Medicaid covered service.
25 – General Administration	*Activity*: A nurse submits her monthly summary for time card. *Explanation:* Activities related to payroll are general administrative in nature and are reported as Code 25. Activities reported as Code 25, generally, are not client-focused or related to a specific program.
26 – Paid Time Off	*Activity*: An outreach worker takes a vacation day. *Explanation*: Paid leave time should be reported as Code 26.
27 – Time Not Scheduled to Work	*Activity*: A nurse is scheduled to have every other Friday afternoon off. *Explanation*: A random moment that occurs on Friday afternoons when the nurse is not scheduled to work in the claiming unit is reported as Code 27.
Outreach and Eligibility	
4 – Non-Medicaid Outreach	*Activity*: A public health employee gives a client a list of food banks in his neighborhood. *Explanation*: Informing individuals about social services or other non-Medicaid services and how to access them is reported as Code 4.
3 – Medicaid Outreach	*Activity*: A nurse gives information about applying for Medicaid and First Steps/Medicaid services to a pregnant teen in need of medical care. *Explanation*: Providing information about Medicaid so that the person can become eligible and about Medicaid covered services for the purpose of bringing an individual into the Medicaid system of care are outreach activities reported as Code 3.
6 – Facilitating Eligibility for Non-Medicaid Programs	*Activity:* A clerk in a public health office gives information by phone about eligibility requirements for WIC. *Explanation*: Explaining eligibility rules and the eligibility process for non-Medicaid programs, such as WIC, TANF, SSI, etc., as well as assisting with applications for these programs is reported as Code 6.
5 - Facilitating Medicaid Eligibility Determinations	*Activity*: A social worker assists a parent to complete a Children's Medicaid application and copy proofs required for the application (such as birth certificates, Social Security Numbers, mother's pay stubs). .*Explanation*: Helping someone to complete an application for Medicaid benefits is reported as Code 5. Explaining eligibility rules and the eligibility process for Medicaid is also Code 5. Do not report billing for Medicaid services under this

	code.
10 – Outreach and Access to Oral Health Care for Medicaid Children	*Activity:* A dental assistant helps a parent schedule dental appointments for her children, who are enrolled in the ABCD dental program. *Activity:* A program manager discusses the best way to distribute outreach material on the ABCD program with the manager of the local public library. *Explanation:* Outreach to link Medicaid children 0-18 years old into oral health care is reported as Code 10. Also, report time spent recruiting providers to accept Medicaid children into dental care to this code.
Referral and Service Coordination	
7 – Referral, Coordination & Monitoring of Non-Medicaid Services	*Activity:* A home visiting nurse refers a client to section 8 housing. *Explanation:* Time spent making a referral to housing or any service that is not covered by Medicaid is reported as Code 7.
8 – Referral, Coordination & Monitoring of Medicaid Services (medical health, dental, mental health, and substance abuse)	*Activity:* A public health nurse refers a client to a Medical Center Hepatitis Clinic for follow up with his Hepatitis C diagnosis. *Activity*: A few days later she checks back with the client to make sure he was able to keep the appointment, and to assist with arrangements for recommended medical care. *Explanation*: The time the nurse spends making a referral to a service covered by Medicaid is reported as Code 8. The time spent following up on the referral is also Code 8.
9 – SPMP Medical Care Coordination	
9A – SPMP Care Management to Assess Need for and Adequacy of Medical Care Services	*Activity:* A licensed clinical social worker meets with a consumer who was recently hospitalized to determine her needs for outpatient psychiatric services and other medical care now that she's living in the community. *Explanation*: Using medical/clinical skills and knowledge to determine an individual's need for mental health (or medical, dental or substance abuse) care and services is reported as Code 9A. *Activity:* A licensed clinical social worker consults with a PHN in the field regarding an individual's physical and mental condition and developed a plan to refer individual to urgent care. *Explanation:* Care management in Code 9A may also include consulting with other medical providers about an individual's need for and adequacy of medical care services.
9B – SPMP Anticipatory Guidance to Facilitate Medical Care and Treatment for Complex Health Need	*Activity:* A public health nurse makes a home visit to provide information to the foster parents of a four-month old infant born addicted to drugs on the signs of drug addiction, rationale for and importance of following Phenobarbital regime, cues, suggestions for calming baby and emergency numbers if unable to calm him. *Explanation*: Using medical knowledge and skills in providing anticipatory guidance to facilitate medical care and treatment for complex health needs is reported as Code 9B.
Training	
11 – Training to Improve	*Activity*: An epidemiologist attends training on investigation procedures for insect-borne illnesses.

Skills in Non-Medicaid Services	*Explanation*: Training related to improving skills in delivering services that are not covered by Medicaid is reported as Code 11.
9D – SPMP Training to Improve the Skill Level of SPMP Staff in Performing Allowable SPMP Activities	*Activity:* A nurse practitioner attends training on quality management processes related to doing site reviews to ensure medical quality of services provided in STD and family planning clinics. *Explanation:* Training received by SPMP to assist them in carrying out SPMP functions (such as care management or utilization review functions) is reported as Code 9D. Training provided by SPMP to staff members and providers is not included in this code. Non-SPMP report training related to MAM activities under the code to which the training relates. Providing or attending training related to professional development or general in-services or training is reported as Code 25, General Administration.
Transportation and Translation	
13 – Arranging Transportation for Non-Medicaid Services	*Activity:* A case aide arranges transportation for a mother and her infant to get to a WIC appointment. *Explanation*: Arranging, scheduling or providing transportation so that an individual can access WIC or other services not covered by Medicaid is reported as Code 13.
12 – Arranging Transportation for Medicaid Services	*Activity*: A case aide helps an individual arrange transportation through the DSHS Medicaid transportation brokerage system so that she can get her children to their Healthy Kids exams. *Explanation:* Time spent educating clients on the Medicaid transportation brokerage system and assisting individuals to arrange transportation to Medicaid services using the transportation brokerage system are reported as Code 12. Assisting a client to access a Medicaid service through an informal transportation resource (such as arranging for a neighbor to transport) is reported to Code 8.
17 – Interpretation for Non-Medicaid Services	*Activity*: A bilingual clerk interprets for a public health nurse who is gathering information from a non-English speaking client in order to refer her to a domestic violence shelter. *Explanation*: Interpretation services that assist an individual to access non-Medicaid services are reported to Code 17. Time spent arranging interpretation so that an individual can access a non-Medicaid service is also reported to this code.
14 – Interpretation for Medicaid-Covered Medical Services	*Activity*: A DSHS certified interpreter provides interpreter services during a public health nursing home visit to a MSS client. *Explanation*: Agencies that have a contract with the DSHS Interpreter Service Program and have staff or contractors who are certified and/or qualified by DSHS or a LHJ to furnish interpreter services report interpretation provided as part of a Medicaid-covered medical service to Code 14. Interpretation services furnished during a patient care visit by a direct care provider or by staff of agencies that do not have a contract with the DSHS Interpreter Services program should be reported to Code 1.
15 – Interpretation for Medicaid-Related Outreach Activities	*Activity*: A DSHS certified interpreter translates a brochure on immunizations to be used in an outreach campaign focused on Medicaid families in specific zip codes of the county. *Explanation*: Staff or contractors of an agency that has a contract with the DSHS Interpreter Services program that are certified and/or qualified by DSHS or a LHJ to provide interpretation services report time interpreting

	information about the Medicaid program, to eligible or potentially eligible individuals, including written translation of outreach material, to Code 15.
16 – Interpretation for Medicaid-Related Linkage Activities	*Activity*: A DSHS certified interpreter helps a Spanish-speaking mother schedule an evaluation for her hearing-impaired child with an audiologist. *Explanation*: Staff or contractors of an agency that has a contract with the DSHS Interpreter Services program that are certified and/or qualified by DSHS or a LHJ to provide interpretation services report time interpreting that assists an individual to access Medicaid-covered services to Code 16.
Vaccine Quality Improvement	
18 – Vaccine Quality Improvement/Child Profile Activities	*Activity:* A program assistant enters VFC immunization data into computer for monthly vaccine report. *Explanation:* Activities to administer or support the vaccine quality improvement program, including data entry related to Child Profile and the State immunization registry and oversight of the doses of state-supplied vaccine, are reported as Code 18. SPMP use this code when performing activities related to the vaccine quality improvement program, which do not require their professional medical knowledge and skills. Administering vaccines is reported as Code 1.
9F – SPMP Vaccine Quality Improvement	*Activity:* Using her medical knowledge and skills, a vaccine nurse consultant prepares recommendations to public health clinics for prioritizing flu vaccine doses for specific high-risk groups, based on their medical diagnoses. *Explanation:* Activities involved in providing clinical oversight of the monitoring, handling, distribution and control of vaccines that require medical knowledge and skills are reported as Code 9F. This code also includes coordinating the medical aspects of vaccine programs, site reviews to ensure the medical quality of vaccine administration, and exchanging and providing medical information with medical providers to ensure the overall quality of vaccine programs.
Systems Level Activities	
20 – Community Resource Development, Systems Planning & Interagency Coordination of Non-Medicaid Services	*Activity:* A social worker participates in a planning meeting to develop an after-school program for middle school youth. There are several community agencies involved. *Explanation:* As no specific Medicaid services are being planned, this interagency planning/community resource development activity is reported as Code 20.
19 – Community Resource Development, Systems Planning & Interagency Coordination of Medicaid Services	Activity: A nurse participates in a Covering Kids and Family Coalition meeting, which is developing statewide initiative to increase Medicaid outreach programs and funding options. *Explanation:* Activity related to developing or planning services, programs and resources that relate to Medicaid covered medical/dental/mental health/chemical dependency services, as well as interagency activities to improve the availability, quality and cost-effectiveness of the Medicaid health care delivery system are reported as Code 19. Collecting and analyzing Medicaid data to identify needs or improve service coordination and delivery is also reported to this code.
9C – SPMP Interagency	*Activity*: A registered dietician facilitates a community meeting of pediatric dietitians who provide enteral

Coordination to Plan, Improve, or Monitor the Delivery of Medical Services	nutrition services and/or make referrals for enteral nutrition services in the community to discuss the nutritional needs of children with special health care needs and their access to enteral nutrition services. *Explanation*: An SPMP using clinical knowledge and skills to facilitate interagency coordination to plan, improve or monitor delivery of a Medicaid service would report these activities as Code 9C. This code also includes meeting with medical providers to improve the medical aspects of Medicaid services.
9E – SPMP Internal Quality Management	*Activity:* A nurse reviews quality assurance and performance standards for MSS for the purpose of developing a CQI program monitoring tool. *Activity*: A nurse does an audit of family practice charts. *Explanation*: Using medical knowledge and skills to develop standards and protocols is reported as Code 9E. Other quality management activities, such as utilization reviews and ongoing evaluations, related to Medicaid covered services are also reported to this code.
22—Non-Medical Provider Relations	*Activity:* A nurse contacts community agencies to gather information on available parenting education programs, in order to develop referral sources for their clients. *Explanation:* Staff report time developing resource directories and referral sources for non-medical services as Code 22.
21 – Medicaid Provider Relations	*Activity:* A nurse compiles a list of OB-GYNs in the community that take medical coupons (take Medicaid patients) to give to prenatal clients. *Explanation:* Developing medical service/provider directories for Medicaid services is reported as Code 21. Recruiting medical/dental/mental health providers to service Medicaid eligible individuals and providing technical assistance and support to them is also reported to this code.
Medicaid Administrative Claiming Implementation	
23 – Medicaid Administrative Claiming Coordination and Claims Administration	*Activity:* A fiscal coordinator prepares the local health jurisdiction's MAC invoice. *Activity:* A RMTS coordinator reviews quarterly time survey reports in order to plan time survey training for claiming unit staff. *Explanation*: Only LHJ staff with designated responsibility for managing components of the AdMatch program (such as overall program administration, administration of the RMTS, or preparing the invoice) report their activity as Code 23.
24 – Medicaid Administrative Match Implementation Training	*Activity:* A nurse attends a training session on the MAC random moment time survey. *Explanation:* Staff participation in MAC training is reported as Coded 24. Giving or attending training that improves skills of SPMP and non SPMP staff to perform outreach and linkage to the Medicaid program and Medicaid covered services is also reported as Code 24.

THE MOST COMMON CODING PROBLEMS
in the February RMTS Pilot:
A Beginning List

1. NO LINK TO MEDICAID			
ORIGINALLY CODED AS	TO BE RECODED AS	AS WRITTEN	COMMENTS
3	2	At meeting with UW nursing students to plan health fair for Medicaid families for prevention of illness practice.	This does not appear to have any link to Medicaid services.
3	8 (with Medicaid link described)	Telephone call about resources with a MOMS client.	The types of resources aren't described; no apparent link to Medicaid services. Appears that purpose not about bringing mom into services, but referring her on to other services??? May be better reported to Code 8.
8	8 (with Medicaid link described)	Completing paperwork for new referral to give to PH nurse in order for her to contact client	Needs to show link to Medicaid service.
8	8 (with Medicaid link described)	Entered PHN referral into SKRTS data base.	Needs link to Medicaid service.
8	8 (with Medicaid link described), 10 if no link to Medicaid	Visiting a deaf client with an SNL interpreter.	No link to Medicaid services.
8	8 (with Medicaid link described)	Wrote letter with application and intake form to parent of child with special health care needs explaining CSHCN program and sending resource information.	Wrote letter with application and intake form to parent of child with special health care needs explaining *medical services available through* CSHCN program and sending resource information.
8	8 (with Medicaid link described), 10 if no link to Medicaid	Took referral from health care provider regarding service for a family whose 4 year old has asthma.	Not clear whether medical services are what child needs.
10	15 (new Code 13)	Assisting client on Medicaid to arrange transportation.	No link to Medicaid services.
13	15 (new Code 17)	DSHS certified interpreter -translating and formatting written materials for childcare program at health department.	No link to Medicaid services.
18	18 (new Code 19, with Medicaid link described), 19 (new Code 20, if no link to Medicaid)	Worked with outlying school system to plan a clinic serving a Medicaid eligible group.	Not clear whether a Medicaid service will be provided. If not, this activity should be reported to Code 19 (new Code 20).
18	2	Working on data request around adolescent smoking and drinking habits.	Miscoded? No link to Medicaid.
18	18 (with Medicaid link described), 19 if no link to Medicaid	Attended health and wellness meeting with other community agencies.	No link to Medicaid services.
18	21 (new Code 22)	Met with program manager to discuss educational materials needed for a training at contract agency.	No link to Medicaid services - appears to be Non-Medical Provider Relations.
2. MISCODING			
CODE		AS WRITTEN	COMMENTS
19	25	E-mailing staff -attempting to get phones working.	This should be reported to Code 25: General Administration.
8	1	Opening eligible clients to services.	Appears to be linked to provision of direct service.
8	1	Reviewing my client caseload to see who needs to be seen and rescheduled.	Appears to be linked to provision of direct service.
8	1	Charting on a First Steps client	As part of billable service, needs to be reported to Code 1.

THE MOST COMMON CODING PROBLEMS
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A Beginning List

10	8,10, or 25	Returning from an IFSP meeting	Meeting could have focused on both Medicaid and non-Medicaid services. If the meeting was just on non-Medicaid services, then Code 10 is correct. If just Medicaid, then Code 8. If both, use Code 25 and note that IFSP meeting discussed both Medicaid and non-Medicaid services.
18	19 (new Code 20)	Putting a press release into Health Department's website regarding March of Dimes grant which will cover tobacco cessation clases for women of childbearing age and education on folic acid and vitamins.	No link to Medicaid. Should be reported to Code 19 (new Code 20).
25	1	Complete daily contact log and failed appointments for MSS intakes.	As part of billable service, needs to be reported to Code 1.
25	1 or 9B	Documenting patient teaching done to clarify need for child to be followed closely by pediatrician.	If done as part of billable service, would be Code 1. If not, would be appropriate as Code 9B; Anticipatory Guidance.
25	1	Organzing First Steps meeting to discuss documentation.	This is part of a billable service, should be reported to Code 1.
3. GENERAL ADMINISTRATION USED AS A CATCHALL			
CODE		AS WRITTEN	COMMENTS
25	?	Documentation on non-Medicaid client.	Needs to be coded to the activity for which the charting was done.
25	2,5 (new Code 4), or 8	Talking to physician office to obtain client address for notifiable condition.	If purpose of letter to client is to inform about condition, then Code 2 or Code 5 (new Code 4) should be used, as there is no link to Medicaid. If letter is to inform person about available medical treatment, then Code 8 could be used.
25	8 or 18 (new code 19)	Analyzing client data to determine eligibility for CSHCN program.	If this activity is focused on a single child, then Code 8 should be used to reflect an early step in linking child to Medicaid services. If the data review was at the systems level, focused on many children, then Code 18 (new Code 19)could be used to reflect planning around improving access to the Medicaid services covered by CSHCN.
25	?	Reviewing protocol to handle meningococcal outbreak response.	Protocol probably has several elements. The review probably took more than a minute; what part was being read at time of random moment? Was there a link to Medicaid services?
25	2	Organizing nutrition packets for Basic Food Program	This is an activity supporting a non-Medicaid service, should be reported to Code 2.
25	?	Meet with principal where TB outbreak occurred.	The purpose of the meeting is not described, or what was being discussed at the time of the random moment. Description covers more than a minute of activity.
25	16 (new code 18)	Data entry vaccine received	This is linked to vaccine quality improvement, should be reported to Code 16 (new Code 18)..
25	1 or 8	Talking to case manger about client's plans to move out of state later in the month.	This is a client-related activity. Use Code 1 if related to direct service such as MSS, Code 8 if discussion related to referral and coordination of Medicaid services.
25	22 (new Code 7)	Change scheduling for Spanish interpreter for ABCD	Since this activity is related to the ABCD program, it should be reported to this activity code - Code 22 (new Code 7).
4. DESCRIPTION COVERS MORE THAN ONE MINUTE OF ACTIVITY			
CODE		AS WRITTEN	COMMENTS
25	?	Downtown for HIV Outreach and Syringe Exchange	Needs NOT to be reported to General Administration, and to reflect what was done at the time of the random moment.
25	1 or 9B	Documenting patient teaching done to clarify need for child to be followed closely by pediatrician.	This appears to be a good example of anticipatory guidance (9B), if not done as part of a billable service or clinic visit.

THE MOST COMMON CODING PROBLEMS
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A Beginning List

3	2 or 3	I was wrapping up a class I did with a domestic violence support group. As part of my outreach I discussed with them the services that Auburn Public Health prpovides, including assisting them to get on Medicaid and Take Charge.	A good example of Medicaid Outreach ,but covers a lot more than one minute.
25	2 or 18 (new Code 19)	Attended meeting between Children and Family Health Division at WA Dept of Health and LHJs - discussion at this time was WIC program case distribution and change in providers statewide as well as WIC integration with other programs such immunization.	Could be reported to Code 2 if focus on WIC, Code 18 (new Code 19)if focus on immunizations.
5. PLANNING AND INTERAGENCY FUNCTIONS ARE NOT CODED CONSISTENTLY			
CODE		AS WRITTEN	COMMENTS
8		Prep for meeting with First Steps staff re: TERM project - to insure referral, linkage, coordination	This appears to be a systems, rather than client-specific activity focused on improving access to Medicaid services.
10	18 (new Code 19)	Smile Survey oral health screenings	Should be Code 18 (new Code 19), if it is correct that the screenings are done to assess the oral health of specific child populations, in order to better plan and deliver needed oral health services.
18	8	Trying to find a care manager for woman with active TB and epilepsy to reduce her use of emergnecy room.	This appears to be interagency coordination around a single indiviudal,would be better reported to Code 8.
6. ACTIVITIES RELATED TO THE RMTS ARE MISCODED			
CODE		AS WRITTEN	COMMENTS
3	24	Reading Medicaid match training materials.	This should be reported to Code 24.
25	24	Completing RMTS	This should be reported to Code 24.
7. PURPOSE OF ACTIVITY NOT DESCRIBED, ONLY THE EVENT			
CODE		AS WRITTEN	COMMENTS
2		Consulting with provider about services for clients	This could be Code 3, if purpose was to help determine whether client is eligible for Medicaid.
8		Helping client on the phone	Purpose of phone conversation needs to be described.
8		Consulting with provider about services for clients	Purpose of consultation needs to be described.
8		Participated in multi-disciplinary team for case conference.	Needs purpose, link to Medicaid.
8		Processing PHN visit encounters	Needs purpose of encounters, link to Medicaid.
18		Attending county homeless coalition meeting	Purpose not explained, no link to Medicaid.
8. MEDICAID-RELATED ACTIVITIES ARE REPORTED TO NON-MATCHABLE OR WRONG CODES			
CODE		AS WRITTEN	COMMENTS
2	3?	Assisting patient to see application worker to get child on medical coupons	This appears to be Medicaid outreach.
19	?	Cataloguing different resources in community that we assist clients with in order to better serve families.	What kinds of resources?
19	?	talking to staff in a pediatric office.	About what?
8	6 (new Code 5)	Advocacy/referral to local CSO to get parent's SSI/Medicaid reinstated.	This should be Code 6 (new Code 5), as it is related to Medicaid eligibility.

THE MOST COMMON CODING PROBLEMS
in the February RMTS Pilot:
A Beginning List

8	3	Talking with CSHCN child's mohter about managed care medical coverage and need to have open coupon to access regular physician	Assuming that the child is on Medicaid, this would be more appropriately reported to Code 3: Medicaid Outreach.
5	?	Orally informed non-Medicaid asylee about legal and medical services.regarding his health screening.	It is not clear whether part of this activity (which rperesents more than a minute) is about linkage to Medicaid-covered services. The Medicaid status of the person should not be used to determine the activity code, but rather what the employee was doing at that time.
10	8	Following up on mental health issues for CPS client.	As a referral to Medicaid service, should go to Code 8
19	8	Directing client to dentists that accepts adult medical coupons.	Should be reported to Code 8, as the service is covered by Medicaid. Medicaid status is not considered in Code 8..
9. CODING IS LINKED TO MEDICAID STATUS OF CLIENT, NOT THE ACTIVTY			
CODE		AS WRITTEN	COMMENTS
2		Abnormal pap follow up on non-Medicaid client.	Coded correctly if done as part of office visit, if follow up is to medical providerand not linked to clinic visit, then could be reported to Code 8.
5		Outreach activity with pamphlets to non-Medicaid clients.	Content of pamphlets should determine whether the outreach activity should be reported to Code 3, Code 5 (new Code 4), Code 8, or Code 10.

	Claiming Entity:			MEDICAID ADMINISTRATIVE MATCH									
	Claiming Program:												
	Claiming Unit:			INVOICE									
	Period of Service:									Invoice #:			
	COST CATEGORIES:		FORMULA alpha = line numeric = cost pool	CP#1 SPMP (Enter)	CP#2 Non-SPMP (Enter)	CP#3a Non-Claim. (Enter)	CP#3b (Formulas) Non-Claim. Bal. from Dir. Chg.	CP#4 (Formulas) DIRECT CHARGES ENHANCED	CP#5 (Formulas) DIRECT CHARGES NON-ENHANCED	CP #6 (Enter) Allocated Cost & Revenue			
A	Salary		(Enter)				-	-	$0		0		
B	Benefits		(Enter)				-	-	$0		0		
C	Travel and Training		(Enter)				-	$0	$0				
D	SUBTOTAL		A+B+C	$0	$0	$0	$0	$0	$0	$0			
E	Personal Service Contracts		(Enter)				-	$0	$0	XXXXXXX			
F	SUBTOTAL PERSONNEL		D+F	$0	$0	$0	$0	$0	$0	$0			
HA	Indirect if rate based on personnel only (rate entered in Other Information Worksheet, G15)		F x Indirect Rate	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	0		
G	Distribution %		F/(CP1...CP5)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	XXXXXXX			
H	Other Costs		(Enter)				$0	XXXXXX	$0		0		
I	Costs to be Distributed		F6+H6+Ha6	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXX	XXXXXXXXX	$0	0		
J	Distribution of Costs		I6 x G	$0	$0	$0	$0	$0	$0	XXXXXXX			
K	SUBTOTAL OTHER COSTS		H+HA+J	$0	$0	$0	$0	$0	$0	XXXXXXX			
L	Collapse CP#3b		F3b + K3b	XXXXXXXXX	XXXXXXXXX	$0	XXXXXXXXX	XXXXXX	XXXXXXXXX	XXXXXXX			
HB	Indirect if rate based on total costs (rate entered in Other Information Worksheet, G15)		(F+K+L) x Indirect Rate	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**		0		
M	TOTAL COSTS		F + K + L + HB	$0	$0	$0	XXXXXXXXX	$0	$0	XXXXXXX	0		
N	% OF TOTAL COST		M/(CP1-CP5)	0.00%	0.00%	0.00%	XXXXXXXXX	0.00%	0.00%	XXXXXXX			
	FUNDING SOURCE ADJUSTMENT:				ALL FORMULAS								
O	Revenue Offset		From Funding Sources	$0	$0	$0	XXXXXXXXX	$0	$0	$0			
P	Reallocated CP#6 Revenue		O6 X N	$0	$0	$0	XXXXXXXXX	$0	$0	XXXXXXXX			
Q	TOTAL REVENUE REQUIRING OFFSET		O + P	$0	$0	$0	XXXXXXXXX	$0	$0	XXXXXXXX			
R	Non-Claimable Services Cost: CP#3		L3	XXXXXXXXX	XXXXXXXXX	$0	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXX			
S	Non-Claimable Service Cost: CPs #1 & 2		L x	$0	$0	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXX			
T	Remaining Funding Sources CP#3		(Q-R)>$0	XXXXXXXXX	XXXXXXXXX	$0	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXX			
U	Distribution %		S1/(S1+S2);S2/(S1+S2)	0.00%	0.00%	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXX			
V	Reallocated CP#3 Funding Sources		T3 x U	$0	$0	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXX			
W	Remaining Revenue		If L=$0 or V<S,Q;else,V-	$0	$0								
X	Revenue to Personnel Services		If E=0,0; else W * E/M	$0	$0								
XX	Revenue to Other Costs		If J=0,0; else W * J/L	$0	$0								
Y	Adjusted Personnel Services Cost		If (E-X)=0,0; else E-X	$0	$0								
YY	Adjusted Other Cost		If (J-XX)=0,0; else J-XX	$0	$0								
Z	TOTAL ADJUSTED COST		Y+YY	$0	$0	XXXXXXXXX	XXXXXXXXX	$0	$0	XXXXXXXX			
	ACTIVITIES	RMS CODE	(Enter) MEDICAID %	(Enter) ACTIVITY RESULTS PERCENTAGES SPMP	(Enter) NON-SPMP								
AA	Medicaid Outreach	3	100.00%										
AB	Non-Medicaid Outreach	4	XXXXXXXXX										
AC	Facilitating Medicaid Eligibility	5	100.00%										
AD	Facilitating Non-Medicaid Eligibility	6	XXXXXXXXX										
AE	Referral, Coordination, Monitoring of Non-Medicaid Service	7	XXXXXXXXX										
AF	Referral &Coordination of Medicaid Services	8	0.00%										
AG	SPMP Medical Care Coordination (total 9A-9E)	9A-9E	0.00%		XXXXXXXX								
AH	SPMP Vaccine Quality Improvement	9F	0.00%		XXXXXXXX								
AI	Outreach for Oral Health for Medicaid Children	10	100.00%										
AJ	Training for Non-Medicaid Services	11	XXXXXXXXX										
AK	Medicaid Transportation	12	0.00%										
AL	Non-Medicaid Transportation	13	XXXXXXXXX										
AM	Interpretation for Direct Medical Services	14	100.00%										
AN	Interpretation for Medicaid Outreach	15	100.00%										
AO	Interpretation for Medicaid Linkage	16	0.00%										
AP	Interpretation for Non-Medicaid Services	17	XXXXXXXXX										
AQ	Vaccine Quality Improvement/Child Profile Activities	18	0.00%										
AR	Program Planning & Policy Development for Medicaid	19	0.00%										
AS	Program Planning & Policy Development for Non-Medicaid	20	XXXXXXXXX										
AT	Medicaid Provider Relations	21	0.00%										
AU	Non-Medicaid Provider Relations	22	XXXXXXXXX										
AV	Medicaid Claims Coordination/Claims Administration	23	100.00%										
AW	MAC Implementation Training	24	100.00%										
AX	Direct Patient Care	1	XXXXXXXXX										
AY	Other Programs and Activities	2	XXXXXXXXX										
AZ	General Administration	25	XXXXXXXXX										
AAZ	Paid Time Off	26	XXXXXXXXX										

ABZ	TOTAL TIME			0.00%	0.00%								

	Period of Service:		Claiming Unit:		t								
						ALL FORMULAS							
						1	11		111				
	ALLOCATE ADMINISTRATION & PAID TIME OFF &					Apply MER			Apply MER				
	APPLY MEDICAID %	(Formula - Disc Column)		Medicaid %	SPMP	SPMP (50%)	SPMP (75%)	Non-SPMP	Non-SPMP (50%)				
BA	Medicaid Outreach	{AA/SUM(AA..AZ)}xMA%		100.00%	0.00%	0.00%	XXXXXX	0.00%	0.00%				
BB	Facilitating Medicaid Eligibility	{AC/SUM(AA..AZ)}xMA%		100.00%	0.00%	0.00%	XXXXXX	0.00%	0.00%				
BC	Referral, Coordination of Medicaid Services	{AF/SUM(AA..AZ)}xMA%		0.00%	0.00%	0.00%	XXXXXX	0.00%	0.00%				
BD	SPMP Medical Care Coordinatiion	{AG/SUM(AA..AY)}xMA%		0.00%	0.00%	XXXXX	0.00%	XXXXXX	XXXXXX				
BE	SPMP Vaccine Quality Improvement	{AH/SUM(AA..AZ)}xMA%		0.00%	0.00%	XXXXX	0.00%	XXXXXX	XXXXXX				
BF	Oral Health for Medicaid Children	{AJ/SUM(AA..AZ)}xMA%		100.00%	0.00%	0.00%	XXXXXX	0.00%	0.00%				
BG	Medicaid Transportation	{AL/SUM(AA..AZ)}xMA%		0.00%	0.00%	0.00%	XXXXXX	0.00%	0.00%				
BH	Interpretation for Direct Medical Services	{AM/SUM(AA..AZ)}xMA%		100.00%	0.00%	0.00%	XXXXXX	0.00%	0.00%				
BI	Interpretation for Medicaid Outreach	{AN/SUM(AA..AZ)}xMA%		100.00%	0.00%	0.00%	XXXXXX	0.00%	0.00%				
BJ	Interpretation for Medicaid Linkage	{AP/SUM(AA..AZ)}xMA%		0.00%	0.00%	0.00%	XXXXXX	0.00%	0.00%				
BK	Vaccine Quality Improvement/Child Profile	{AQ/SUM(AA..AZ)}xMA%		100.00%	0.00%	0.00%	XXXXXX	0.00%	0.00%				
BL	Program Planning and Policy Development	{AS/SUM(AA..AZ)}xMA%		0.00%	0.00%	0.00%	XXXXXX	0.00%	0.00%				
BM	Medicaid Provider Relations	{AU/SUM(AA..AZ)}xMA%		0.00%	0.00%	0.00%	XXXXXX	0.00%	0.00%				
BN	Medicaid Claims Coordination/Claims Administration	{AV/SUM(AA..AZ)xMA%		100.00%	0.00%	0.00%	XXXXXX	0.00%	0.00%				
BO	MAC Implementation Training	{AW/SUM(AA..AZ)		100.00%	0.00%	0.00%	XXXXXX	0.00%	0.00%				
BP	Direct Patient Care	{AZ/SUM(AA..AZ)		XXXXXXXXXX	0.00%	XXXXXX	XXXXXX	0.00%	XXXXXX				
BQ	Other Programs/Activities	{AB/SUM(AA..AZ)		XXXXXXXXXX	0.00%	XXXXXX	XXXXXX	0.00%	XXXXXX				
BR	Non-Medicaid Outreach	{AD/SUM(AA..AZ)		XXXXXXXXXX	0.00%	XXXXXX	XXXXXX	0.00%	XXXXXX				
BS	Facilitating Eligibility for Non-Medicaid Programs	{AE/SUM(AA..AZ)		XXXXXXXXXX	0.00%	XXXXXX	XXXXXX	0.00%	XXXXXX				
BT	Non-Medicaid Referral, Coordination	{AI/SUM(AA..AZ)		XXXXXXXXXX	0.00%	XXXXXX	XXXXXX	0.00%	XXXXXX				
BU	Training for Non-Medicaid Services	{AK/SUM(AA..AZ)		XXXXXXXXXX	0.00%	XXXXXX	XXXXXX	0.00%	XXXXXX				
BV	Non-MedicaId Transportation	{AO/SUM(AA..AZ)		XXXXXXXXXX	0.00%	XXXXXX	XXXXXX	0.00%	XXXXXX				
BW	Non-Medicaid Interpretation	{AR/SUM(AA..AZ)		XXXXXXXXXX	0.00%	XXXXXX	XXXXXX	0.00%	XXXXXX				
BX	Non-Medicaid Program Planning	{AT/SUM(AA..AZ)		XXXXXXXXXX	0.00%	XXXXXX	XXXXXX	0.00%	XXXXXX				
BY	Non-Medicaid Provider Relations	[AU/sum(AA..AZ)		XXXXXXXXXX	0.00%	XXXXXX	XXXXXX	0.00%	XXXXXX				
BZ	TOTAL				0.00%	0.00%	0.00%	0.00%	0.00%				
						1	11		111				
	TOTAL ALLOCATED TIME				SPMP:	0.00%	Non-SPMP	0.00%					
	Outreach & Linkage					0.00%	0.00%		0.00%				
	Interpretation					0.00%			0.00%				
	ABCD/Dental					0.00%			0.00%				
	Vaccine QA/CHILD Profile					0.00%	0.00%		0.00%				
					ALL FORMULAS								
						Outreach & Linkage		Interpretation	ABCD/Dental	Vaccine QA			
	CLAIM CALCULATION:			SPMP	Non-SPMP	SPMP	Non-SPMP						
CA	Federal Non-Enhanced Basis (50% FFP) Cost Pool #1		Z x (BZ1)+ (YY x BZ11)	$0		$0		$0	$0	$0			
	Federal Non-Enhanced Basis (50% FFP) Cost Pool #2		Z x (BZ111)		$0		$0	$0	$0	$0			
CB	Federal Non-Enhanced (50%FFP) Share		(CA1 or CA2) x 50%	$0	$0	$0	$0	$0	$0	$0			
CC	Federal Enchanced (75% FFP) Basis		Y1 x (BZ11)	$0	XXXXXXXX	$0	XXXXXXXX	XXXXXXXX	XXXXXXXX	$0			
CD	Federal Enchanced (75%FFP) Share		CC1 x 75%	$0	XXXXXXXX	$0	XXXXXXXX	XXXXXXXX	XXXXXXXX	$0			
CE	Direct Charge: Enhanced (75% FFP) Federal Share		Z4 x 75%	$0	XXXXXXXXX	$0	XXXXXXXX	XXXXXXXXX	XXXXXXXXX	$0			
CF	Direct Charge:Non-Enhanced Federal (50% FFP) Share		Z5 x 50%	XXXXXXXXX	$0	XXXXXXXXX	$0	$0	$0	$0			
===	==========		==========	==========	==========								
CG	FFP @ 50%		CB1+CB2+CF2		FFP @ 50%	$0							
CH	FFP @ 75%		CC1 + CF1		FFP @ 75%	$0							
CI	TOTAL FEDERAL SHARE		CG+CH	XXXXXXXXX	XXXXXXXXX	$0							
CJ	TOTAL NON FEDERAL NON-ENHANCED SHARE		(CA1 or CA2) x 50%	$0	$0	$0							
CK	TOTAL NON FEDERAL ENHANCED SHARE		CC1 X 25%	$0	xxxxxxx	$0							
CL	TOTAL NON FEDERAL SHARE		CJ+CK			$0							
				MAA ADMINISTRATION FEE		$0							
				NET FEDERAL SHARE		$0							
===	==========		==========	==========	==========								
	Adequate non-federal, matchable funds are avaialbe to support Medicaid administrative expenditures. (Total column F on funding					TRUE	$0						
	worksheet is equal to or greater than the sum of Federal and Non Federal Share - G125+G131)								For MAA Use Only				
									I certify that this claim is in all respects true, correct, supportable by				
	I certify to the best of my knowledge and belief that the information provided on the invoice is true and correct, based on actual expenditures for the period claimed, and that the funds/contribut								available documentation, and in compliance with all terms/conditions,				
	have been expended, as necessary for federal matching funds pursuant to the requirements of 42 CFR 433.51, for allowable administrative activities and that these claimed								laws and regulations governing its payment				
	expenditures have not previously been nor will not subsequently be used for federal match in this or any other program.												
	Typed name of signer			Signature			Date						

								Approved by:					
	Title								Date				
	INVOICE PREPARATION INFORMATION												
	Typed name of preparer			Classification			Telephone #						

Program Duty Statement
Medicaid Administrative Match

Program Name:	
Program Contact:	Time Survey Contact:
Site:	Division:
Org/Proj Coding	Org/Proj Receiving Revenue
Enhanced/SPMP: Yes No	

The primary duties & responsibilities of the program are

The staff consist of

To achieve these objectives, the broad functions and activities the staff provide include

Examples of some of the Medicaid Administrative Match activities the staff perform include, but are not limited to:

Additional activity codes that may be utilized for this program are listed in the document entitled “The Time Survey Activity Codes” in the “Manual for Administrative Match in Local Health Jurisdictions.”

Medicaid Administrative Match

Position Duty Statement

Describe the current duties and responsibilities assigned to a specific position and how they relate to Medicaid. Include the position classification, program or claiming unit name and org/project coding, a brief narrative describing the reporting relationships and functions of the job, the specific assignments or activities performed by the employee, supervision received, and as appropriate, supervision exercised by the position. When duties qualify as a Medicaid Administrative Activity, the proper activity code(s) should be identified following the activity.

When answering yes and no questions, please highlight the correct answer.

Cost Pool #.	Date Initiated/Reviewed:
Job Class #:	Sequence Number:
Program/Site	Org/Proj Coding
Working Job Title	
Name:	Start Date:
Supervisor:	
1. Does this position perform activities that match? **YES NO** [If **Yes**, proceed to next box; if **No**, assign costs to Cost Pool # 3 if non-claimable or proceed to box 3 if support staff.]	
2. Does the position require a skilled professional medical provider? **YES NO** [If **Yes**, assign costs to CP# 1; if **No**, assign costs to CP#2.]	
3. Does this position directly support a skilled professional medical provider and are they supervised by a SPMP? [If **Yes**, assign costs to CP# 1; if **No,** assign costs to CP#2 if they do activities that match or CP # 6 if they provide general support.]	
Job Summary:	
Primary Duties & Responsibilities:	
Additional activity codes that may be utilized for this program are listed in the document entitled “The Time Survey Activity Codes” in the “Manual for Administrative Match in Local Health Jurisdictions.”	